



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 26, 2026

Licensee
Green Lakes Homes
11540 Norway Street Northwest
Minneapolis, MN 55448

RE: Project Number(s) SL39808016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 28, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39808016-0 On July 27, 2026, through July 28, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five (5) resident(s); five (5)receiving services under the Assisted Living Facility license. An immediate correction order was identified on July 27, 2026, issued for SL39808016-0, tag identification 0775. An immediate correction order was identified on July 28, 2026, issued for SL39808016-0, tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risks. Noncompliance remained and the scopes and	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Continued From page 1 levels remain unchanged.	0 000			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 2 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 3 (FBEIR) dated July 28, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility.	0 485			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 485	Continued From page 4 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract indicated the licensee provides a supportive residence. Residents are expected to manage basic daily living activities independently unless additional services are requested. Subject to each resident's needs and service plan, the following are included in the basic monthly fee: Food service - three meals daily served in the dining area. The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked an option for residents to opt out of payment for one, two, or three meals a resident would not want. On July 29, 2026, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the same contract was used for all residents, she agreed the contract does not have an option to opt out of unwanted meals. LALD/CNS-A stated there is no reason why the contract is missing this option and will need to update the contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of three residents (R1 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 On July 28, 2026, at 10:10 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 6 R1 was admitted to the licensee on March 3, 2024. R1's IAPP dated March 3, 2026, indicated R1 was at risk to be abused but did not include: - assessment of the residents' risk of abusing other vulnerable adults or minors. R2 R2 was admitted to the licensee on September 18, 2022. R2's IAPP dated March 5, 2026, indicated R2 was at risk to be abused but did not include: - assessment of the resident's risk of abusing other vulnerable adults or minors. On July 29, 2026, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees the IAPP's for some of the residents are missing the risk to abuse others and is due to an oversight on her part because she did not add the risk to abuse others to the assessment. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living facility services are provided. - the plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. - the plan shall contain the resident's risk of abusing other vulnerable adults. - the plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 7 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included history and symptom screening for one of two employees (unlicensed personnel (ULP)-C, baseline testing for two of two employees (ULP-C and ULP-D) and an updated facility TB risk assessment.	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment was completed January 1, 2026, and indicated the facility was at a low risk for TB transmission, however, the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A updated the risk assessment with information from 2021. ULP-C began employment on June 20, 2024, to provide direct care to residents. ULP-C's employee record included a chest x-ray dated June 18, 2024, but lacked a two-step Mantoux or IGRA blood test and lacked a history and symptom screening. ULP-D began employment on June 24, 2024, to provide direct care to residents. ULP-D's employee record included a chest x-ray dated June 22, 2024, but lacked a two-step Mantoux or IGRA blood test. On July 29, 2026, at 10:00 a.m., LALD/CNS-A stated they do not do two-step Mantoux's or blood tests because their staff decline them so they just send them in for x-rays and thought that would cover the requirements for TB testing. On July 29, 2026, at 10:30 a.m. LALD/CNS-A	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 9 stated she agreed the TB risk assessment was not updated as required with all the required information. The licensee's Tuberculosis and Staff Screening policy dated May 1, 2022, indicated [the facility] shall complete a written community TB risk assessment and update the assessment data on an annual basis. Staff at [the facility] whose essential job functions require work within the same air space of home care clients shall be screened and tested for tuberculosis prior to the staff being exposed to clients. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. New staff shall have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employees' record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 10	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: -maintain and annual EPP updates; -EPP resident population; -process for emergency preparedness collaboration; -policies and procedures for arrangements with other facilities; -policies and procedures for roles under a waiver declared by secretary; -names and contact information; -emergency officials contact information; and -emergency prep testing requirements. On July 29, 2026, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she reviews the missing person policy annually and agrees the EPP is missing some of the required content including resident population, process for EPP collaboration, arrangement with another facility, 1135 waiver, information in the communication plan, and does not have any evidence of an EPP drill twice a year. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 12 during. Periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 700	Continued From page 13 by: Based on observation and interview, the licensee failed to ensure resident records were protected against unauthorized disclosure of electronic records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 29, 2026, at 11:30 a.m., the surveyor observed an unattended computer in the living/dining room of the facility with the cover open and resident information displayed. On July 29, 2026, at 1135 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the computer should not be left open showing private medical information on the residents and this would be a HIPPA (health insurance portability and accountability act) violation. The licensee's Resident Confidentiality policy dated August 1, 2021, indicated all resident information, including but not limited to personal, financial and medical data, will be kept confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775 SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect two residents and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: EGRESS WINDOWS OCCUPIED SLEEPING ROOMS On July 27, 2026, at 11:15 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The egress windows in occupied resident bedrooms were opened by LALD/CNS-A and measured by the surveyor. The egress windows in occupied resident bedrooms one and two did not meet the minimum requirements for safe egress. Egress window measurements: Occupied bedroom one - the clear open area of the window measured 32.75 inches width, 19.75		0 775		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 15 inches height, with a total clear area of 646 square inches. Occupied bedroom two - the clear open area of both windows measured 29 inches width, 19.75 inches height, with a total clear area of 572 square inches. One window in each resident bedroom room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, LALD/CNS-A verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for additional violations related the physical environment under Minnesota Statute 144G.	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 16 including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 17 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 790	Continued From page 18 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 19 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 20 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on March 3, 2024. R2 was admitted on April 5, 2026. R1 and R2's Assisted Living Contracts dated March 3, 2024, and April 3, 2026, lacked inclusion	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 910	Continued From page 22 of the licensee's Health Facility Identification (HFID) number. On July 29, 2026, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the same contract is used for all residents and she agrees the HFID is not on the contract. LALD/CNS-A stated she used a packet for all the admission paperwork, and the packet did not have an HFID included on it so she will need to add it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 23 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment for safe smoking for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 24 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 28, 2026, at 8:20 a.m., the surveyor observed resident (R4) smoking on the back porch. R4 was admitted to the licensee on September 18, 2022, with diagnoses which included major depressive disorder, bipolar disorder, anxiety, history of drug use and nicotine dependence. R4's Service Plan signed November 27, 2023, indicated R4 received assistance with medication administration, ambulation, bathing, dressing, grooming, incontinence care, housekeeping, laundry, safety checks and behavior management. R4's record included 90-day assessments dated January 27, 2026, March 27, 2026, and June 27, 2026. R4's RN assessments as dated above indicated that R4 smoked 1 pack a day and kept his smoking materials in the bedroom, however, the assessment lacked an assessment of R4's ability to smoke safely. On July 29, 2026, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agreed R4's assessment did not indicate if R4 could safely smoke and is missing some of the required	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 25 information. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the RN will conduct A comprehensive assessment utilizing a uniform assessment tool that addresses the following: - smoking, including safety factors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident (R2) who self-administered medications, was assessed for self-administration of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01710	Continued From page 26 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on April 5, 20256, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's medication administration records (MAR) dated June 2026, and July 2026, indicated R2 self-administered Ozempic 0.5mg injection. R2's individualized medication management plan dated July 2, 2026, indicated R2 needs help with medication administration and self-administration of medications is not applicable. On July 29, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the medication assessment for R2 was not updated prior to R2 starting to self-administer the Ozempic and this was because she had missed completing the assessment. The licensee's Assessment of Medications policy dated August 1, 2021, indicated the medication management plan will be evaluated/updated as needed with changes in medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01710	Continued From page 27 days	01710			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 28 reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for two of three residents (R1 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 On July 28, 2026, at 10:10 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1 was admitted to the licensee on March 3, 2024, with diagnoses which included schizoaffective disorder, traumatic brain injury, type 2 diabetes without complications, muscle	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 29 weakness, hypertension, depression and cognitive impairment. R1's Service Plan signed March 3, 2024, indicated R1 received assistance with medication administration, bathing reminders, dressing and grooming assistance, mobility assistance, finance management, incontinence care, laundry, and behavior management. R1's record included an individualized medication management plan dated April 12, 2026, that included: - the statement describing the medication management services that will be provided; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication used to prevent possible complications or adverse reactions. R1's individualized medication management plan lacked the following required information: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 30 R4 R4 was admitted to the licensee on September 18, 2022, with diagnoses which included major depressive disorder, bipolar disorder, anxiety, history of drug use and nicotine dependence. R4's Service Plan signed November 27, 2023, indicated R4 received assistance with medication administration, ambulation, bathing, dressing, grooming, incontinence care, housekeeping, laundry, safety checks and behavior management. R4's record included an individualized medication management plan dated June 27, 2026, that included: - the statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication used to prevent possible complications or adverse reactions. R4's individualized medication management plan lacked the following required information: - identification of the person responsible for monitoring medication supplies and refills: and - identification of medication management tasks	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 31 that may be delegated to unlicensed personnel. On July 29, 2026, at 12:55 d living director/clinical nurse supervisor (LALD/CNS)-A stated she agreed some of the required information is missing from some of the residents medication management plans and this was an oversight on her part. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated The written medication management plan includes the following provisions: - a statement describing the medication management services to be provided; - a description of the storage of medication based on the resident assessment in addressing resident preference, risk of diversion, and instructions per manufacturer; - documentation procedures; - procedures for medication reconciliation; - identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely; - description of medication management tasks to be delegated to unlicensed personnel; - plans for staff notifying the licensed health professional when/if they problem with medication management services arises; and - any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication used to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to ensure medication administration was documented accurately for one of one resident (R2) who had medication management services and failed to ensure prescriber orders were transcribed correctly for three of three residents (R1, R2 and R3) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 33 MEDICATION DOCUMENTATION R2 was admitted on April 5, 20256, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's signed provider orders dated February 15, 2026; included: - semaglutide (Ozempic) 0.5 milligram (mg), inject 0.5 mg subcutaneous once weekly for diabetes. R2's medication administration record (MAR) dated June 1, 2026, to June 30, 2026, indicated R2 was not administered the following medication in June 2026, contrary to the provider orders above: - semaglutide (Ozempic) 0.5mg, inject 0.5mg subcutaneous one weekly for diabetes. R2's MAR dated July 1, 2026, to July 28, 2026, indicated R2 was not administered the following medication in July 2026, contrary to the provider orders above: - semaglutide (Ozempic) 0.5mg, inject 0.5mg subcutaneous one weekly for diabetes. On July 29, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed that the staff are not documenting the administration of the medication on the MAR and there is no reason the documentation has not been completed by the staff but R2 is getting the medication. TRANSCRIPTION ERROR R1	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 34 On July 28, 2026, at 10:10 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1 was admitted to the licensee on March 3, 2024, with diagnoses which included schizoaffective disorder, traumatic brain injury, type 2 diabetes without complications, muscle weakness, hypertension, depression and cognitive impairment. R1's Service Plan signed March 3, 2024, indicated R1 received assistance with medication administration, bathing reminders, dressing and grooming assistance, mobility assistance, finance management, incontinence care, laundry, and behavior management. R1's signed provider orders dated July 1, 2026, included: - albuterol sulfate 90 micrograms (mcg); 2 puffs by mouth 4 times a day as needed for wheezing; - gas relief 125mg; take one capsule by mouth every 8 hours as needed for bloating; - Maalox 30 milliliters (ml); by mouth as needed for gastric distress; - Milk of magnesia 30ml; by moith as needed for constipation; - Robitussin DM 10ml; by mouth as needed, do not exceed 60 ml per day for cough; and - Tylenol 650mg; by mouth as needed, do not exceed 4 grams in 24 hours for pain or fever. R1's MAR dated July 1, 2026, through July 27, 2026, lacked the dosage amount and/or the route of administration for the following medications: - albuterol sulfate; 2 puffs by mouth 4 times a day as needed for wheezing, no dosage indicated;; - gas relief; take one capsule by mouth every 8 hours as needed for bloating, no dosage	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 35 indicated; - Maalox; do not exceed 48 hours without notifying the physician, no dosage or route indicated; - Milk of magnesia; document if effective, no dosage or route indicated; - Robitussin DM; do not exceed 60ml a day, no dosage or route indicated; and - Tylenol; take two tablets by mouth every 8 hours as needed for pain or fever, no dosage or route indicated. R2 R2 was admitted on April 5, 2026, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's signed provider orders dated February 15, 2026; included: - albuterol sulfate 90 micrograms (mcg); 2 puffs by mouth 4 times a day as needed for shortness of breath; and - suvorexant (Belsomra) 10mg; 2 tablets by mouth at bedtime if needed for sleep. R2's MAR dated July 1, 2026, through July 27, 2026, lacked the dosage amount and/or the route of administration for the following medications: - albuterol sulfate; inhale 2 puffs every 4 hours as needed for wheezing, no dosage or route indicated; and - Belsomra; two tablets by mouth as needed for sleep; no dosage indicated. R4 R4 was admitted to the licensee on September	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 36 18, 2022, with diagnoses which included major depressive disorder, bipolar disorder, anxiety, history of drug use and nicotine dependence. R4's Service Plan signed November 27, 2023, indicated R4 received assistance with medication administration, ambulation, bathing, dressing, grooming, incontinence care, housekeeping, laundry, safety checks and behavior management. R4's signed provider orders dated July 14, 2026; included: - hydrocodone/acetaminophen 5/325mg; take 1-2 tablets by mouth every 4 hours if needed for pain. R4's record did not include signed provider orders for the following: - Maalox; - Milk of Magnesia; and - Robitussin DM. R4's MAR dated July 1, 2026, through July 27, 2026, lacked the dosage amount and/or the route of administration for the following medications: - hydrocodone/acetaminophen; take 1-2 tablets by mouth every 4 hours as needed for moderate to severe pain, no dosage indicated; - Maalox; do not exceed 48 hours without notifying the physician, no dosage or route indicated; - Milk of magnesia; document if effective, no dosage or route indicated; and - Robitussin DM; do not exceed 60ml a day, no dosage or route indicated. On July 28, 2026, at 1:00 p.m., LALD/CNS-A stated the reason the dosage and route are missing from the MAR would be a document error on her part.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 37 The licensee's Medication Documentation policy dated August 1, 2021, indicated complete documentation of medication administration includes the following: - resident name; - medication name; - medication dosage; - date and time of administration; - method/route of administration; and - signature and title of staff administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for two of three residents (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 38 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted on April 5, 20256, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's MAR dated July 2026, included the following medications: - meloxicam 15 milligrams (mg); take 1 tablet by mouth daily; - polyethylene glycol 17 grams; take 17 grams by mouth daily, dissolve each 17 grams dose in 240 milliliter (ml) beverage; - Belsomra 20 mg; take two tablets by mouth at bedtime; and - glucose chew 4 gram; chew 1 tablet as needed for low blood sugar. R2's record lacked signed prescriber orders for meloxicam, polyethylene glycol, Belsomra and glucose chew. R4 R4 was admitted to the licensee on September 18, 2022, with diagnoses which included major depressive disorder, bipolar disorder, anxiety, history of drug use and nicotine dependence. R4's Service Plan signed November 27, 2023,	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 39 indicated R4 received assistance with medication administration, ambulation, bathing, dressing, grooming, incontinence care, housekeeping, laundry, safety checks and behavior management. R4's MAR dated July 2026, included the following medications: - A and D ointment; apply to dry area reddened or rash areas; - bacitracin; apply to minor cuts and abrasions; - hydroxyzine pamoate 50 mg; give 2 capsules by mouth every 6 hours as needed; - Ibuprofen 600mg; take 600mg every 6 hours as needed for pain; - Maalox; do not exceed 48 hours without notifying the physician; - Milk of Magnesia; document if effective; - Robitussin DM; do not exceed 60 ml per day; and - Tylenol 650mg; as needed, do not exceed 4 grams in 24 hours for pain or fever. R4's record lacked signed prescriber orders for A and D ointment, bacitracin, hydroxyzine pamoate 50 mg, Ibuprofen 600mg, Maalox, Milk of Magnesia, Robitussin DM, and Tylenol 650mg. On July 28, 2026, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees several medications orders are missing from the resident records and there is no reason other than just an oversight on her part. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from unauthorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 40 over the counter medications. All orders must be signed and dated by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel had access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On July 29, 2026, at 11:30 a.m. the surveyor observed the door of the medication closet open and unattended. The medication closet held the	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 41 medications for all five residents of the facility. On July 29, 2026, at 11:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the medications were not secured and medication closet door needs to be closed and locked at all times. The licensee's Storage/ Control of Medications policy dated August 1, 2021, indicated when [the facility] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for three of three residents (R1, R2 and R3) and the licensee failed to discard expired medications for	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 42 two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at 2:15 p.m., the surveyor and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed the contents of the locked medication closet and found the following: -R1's clozapine 100 milligrams (mg) expired on January 31, 2026. - R1's fluticasone propionate and salmeterol 250/50 mg inhaler lacked an opened or expiration date. -R2's Ozempic 0.5 mg injectable pen lacked an opened or expiration date. -R2's Spiriva Respimat 2.5 micrograms (mcg) inhaler lacked an opened or expiration date. - R3's Wixela 250/50 mcg inhaler lacked an opened or expiration date. - R3's Olanzapine 5 mg expired on July 11, 2026. On July 27, 2026, at 2:20 p.m., LALD/CNS-A confirmed the expiration dates and stated there is no excuse for expired medications, they normally monitor the medication closet once a week and these expired medications should have been discarded. LALD/CNS-A stated she agreed that several of the resident inhalers and injectable pens did not have open or expiration dates on	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 43 them and staff are trained to put date stickers on the medications when first opened but the staff must have missed putting the stickers on. The manufacturer's guidelines for Ozempic dated June 2026, indicated the pen you are using should be disposed of after 56 days, even if it still has medication in it. The manufacturer's guidelines for Spiriva inhaler dated January 2025, indicated after assembly, the inhaler should be discarded at the latest three (3) months after first use or when the locking mechanism is engaged, whichever comes first. The manufacturer's guidelines for Wixela inhaler dated August 2022, indicated safely throw away inhaler in the trash one (1) month after you open the foil pouch or when the counter reads zero (0), whichever comes first. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated the Licensed nurse is responsible for dating time-sensitive medications when opened. The licensee's Medication Administration policy dated August 1, 2021, Indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 44	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided and failed to develop	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 45 and implement a treatment or therapy management plan to include all required content for two of two residents (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on April 5, 20256, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's provider orders signed February 15, 2026, indicated R2 was to have blood glucose testing three times daily. R2's service plan lacked a written statement of the blood glucose monitoring treatment. R2's record lacked an individualized treatment management plan for blood glucose monitoring. R4 On July 29, 2026, at 9:30 a.m., the surveyor observed R4 wearing compression stockings on both legs and an ankle brace on his left ankle. R4 stated the staff assist him with applying the compression stockings and the brace every day.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 46 R4 was admitted to the licensee on September 18, 2022, with diagnoses which included major depressive disorder, bipolar disorder, anxiety, history of drug use and nicotine dependence. R4's Service Plan signed November 27, 2023, indicated R4 received assistance with medication administration, ambulation, bathing, dressing, grooming, incontinence care, housekeeping, laundry, safety checks and behavior management. R4's provider orders signed July 14, 2026, indicated the following treatments: - ankle-foot orthosis (brace) for the left foot; and - graduated compression stockings knee high 15-20 mm Hg (millimeters of mercury) compression stockings. R4's service plan lacked a written statement of the ankle-foot orthosis (brace) or the graduated compression stockings treatments. R4's record contained an individualized treatment management plan dated March 29, 2026, for R4's ankle brace, however, the plan lacked the following required information: - documentation of specific resident instructions relating to the treatments or therapy administration; and - identification of treatment or therapy tasks that will be delegated to unlicensed personnel. R4's record lacked an individualized treatment management plan for graduated compression stockings. On July 29, 2026, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 47 (LALD/CNS)-A stated the treatments for R2 and R4 are not listed on the service plan and there is not a reason why they are missing. LALD/CNS-A stated she does not have a treatment plan for R2's blood glucose monitoring or R4's compression stockings, she did not realize these required treatment plans. LALD/CNS-A stated the reason R4's treatment plan for his ankle brace is missing some of the required information is due to an oversight on her part. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - type of service to be provided; - procedures for documenting treatments or therapies; - procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; - identification of treatment or therapy task delegated to unlicensed personnel; and - procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01970	Continued From page 48 prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 5, 2026, with diagnoses that included schizo-affective disorder, bipolar disorder, diabetes and dementia. R2's service plan signed April 3, 2026, indicated R2 received services to include medication administration. R2's provider orders signed February 15, 2026, indicated R2 was to have blood glucose testing three times daily.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01970	Continued From page 49 On July 29, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was refusing her blood glucose checks and they contacted the provider to discuss getting the order changed to as needed but they have not received a signed order from the provider to discontinue the blood glucose checks. LALD/CNS-A stated the contact with the provider has not been documented anywhere in R2's record. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assist residents. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. All orders must be signed and dated by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 50 review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) who utilized consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at 10:15 a.m., during the entrance conference, the surveyor inquired if the licensee conducted bed rail assessments. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated no residents at the facility had a bed rail. On July 27, 2026, at 11:25 a.m., during a tour of the facility, the surveyor observed a consumer bed rail on the right side of R1's bed. The device was white and black. The upper portion of the bed rail was U shaped with two straight bars on the bottom of the rail that extended to fit under the mattress. The bed rail was placed under the mattress but was not secured with any straps to keep the rail in position. The surveyor pulled on the bed rail and without resistance the rail came out from under the mattress. The surveyor was unable to view any identifying manufacturer information. On July 28, 2026, at 9:30 a.m., R1 stated he got the bed rail to help him get in and out of bed because he had a few falls, he stated he uses it,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 51 but it is not secure and the rail moves around easily when he grabs it. R1 was admitted to the licensee on March 3, 2024, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder, traumatic brain injury, type 2 diabetes without complications, muscle weakness, hypertension, depression and cognitive impairment. R1's Service Plan signed March 3, 2024, indicated R1 received assistance with medication administration, bathing reminders, dressing and grooming assistance, mobility assistance, finance management, incontinence care, laundry, and behavior management. R1's assessment dated June 3, 2026, included a bed safety section which indicated the following: - used a standard bed frame and mattress original to bed; and - the bed safety zone assessment was not applicable, either R1 had no bed rails in use or had portable bed rails that were installed on a consumer bed. R1's lacked a bed rail assessment that included the following required information: - an assessment was completed; - the bed rails were determined to not act as a restraint; - the portable bed rails were installed and maintained according to the manufacturer's guidelines; - the manufacturer's guidelines are accessible upon request; and - the risk vs. benefits were discussed and documented with the resident/responsible party.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 52 On July 27, 2026, at 12:20 p.m., LALD/CNS-A stated she has not completed an assessment for the consumer bed rail on R1's bed, she did not realize he had a bed rail and thinks this may have been a bed rail from a previous resident and he decided to keep it on his bed, but no assessment for the bed rail has been completed. The licensee's Side Rail Use policy dated August 1, 2021, indicated before implementing side rails for a resident, the RN would conduct a side rail assessment that included the following: - level of mobility; - level of consciousness; - level of cognition; - presence of orthostatic hypotension; and - vision. The RN will consider the request of the resident, the resident's legal representative and/or the resident's designated representative request for side rails during the evaluation. The RN will discuss with the resident/representative(s) alternatives to the use of side rails. A physical therapy evaluation may be obtained, as appropriate. If the need for the side rails is indicated and the resident/representative(s) agree to their use, the RN will provide education related to side rails. The RN will document the purpose of the side rails and the education provided. The resident, resident's legal representative will co-sign the document agreeing to the benefits and risks of the side rails. The RN is responsible to ensure that side rails in use are of a safe design and properly maintained. Side rails will be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations are not available, the RN will use appropriate nursing judgement related to the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 53 implementation of the side rails. The need for side rails will be reassessed and documented as needed, but not less than every 90 days. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 17, 2026, "Unlike hospital beds, there is no current published guidance related to portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FAQ also indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, it included, " Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN LAKES HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 54 guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

GREEN LAKES HOMES
11540 Norway Street NW
Minneapolis, MN 55448
Anoka County
Parcel:

Phone:

License Info

License: HFID 39808

Risk:
License:
Expires on:
CFPM: Yashmin Nagujja
CFPM #: 57051; Exp: 03/17/2028

Inspection Info

Report Number: F1013261044
Inspection Type: Full - Single
Date: 7/27/2026 Time: 01:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery:

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 Priority Level: Priority 2 CFP#: 5

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: STAFF DID NOT HAVE A PROCEDURE FOR CLEANUP OF VOMIT OR FECAL MATTER IN THE ESTABLISHMENT. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES AND MDH GUIDANCE DOCUMENT WAS PROVIDED.

Comply By: 7/29/2026 Originally Issued On: 7/27/2026

New Order: 3-500C Microbial Control: date marking

3-501.17A Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT: READY-TO-EAT SLICED WATERMELON WITHOUT A DATE WAS IN THE KITCHEN REFRIGERATOR. PER STAFF THE WATERMELON WAS SLICED 2 DAYS PRIOR. COMPLY WITH RULE. DISCUSSED DATE MARKING PROCEDURES WITH STAFF AND REQUESTED FOOD BE DATE MARKED.

Comply By: 7/27/2026 Originally Issued On: 7/27/2026

New Order: 3-500C Microbial Control: date marking

3-501.17B Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: OPEN PACKAGE OF COMMERCIALY PREPARED READY-TO-EAT TURKEY DELI MEAT WITHOUT A DATE WAS IN THE KITCHEN REFRIGERATOR. PER STAFF THE FOOD PACKAGE WAS OPENED A FEW DAYS PRIOR. COMPLY WITH RULE. DISCUSSED DATE MARKING PROCEDURES AND REQUESTED STAFF DATE MARK THE FOOD.

Comply By: 7/27/2026 Originally Issued On: 7/27/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: FLOOR TILE WAS MISSING IN THE KITCHEN. COMPLY WITH RULE.

Comply By: 10/5/2026 Originally Issued On: 7/27/2026

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator S. Remker.

The establishment has a residential kitchen and serves food prepared on the same day. The kitchen has laminate cabinets, tile floor, smooth painted walls, solid stone counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1013261044 from 7/27/2026

Jerry Malloy

Yashmin Nagujja
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
GREEN LAKES HOMES	Report Number: F1013261044
Minneapolis	Inspection Type: Full
County/Group: Anoka County	Date: 7/27/2026
	Time: 01:00 pm

Food Temperature: **Product/Item/Unit:** Watermelon; **Temperature Process:** Cold-Holding

Location: Refrigerator at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Basement refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Meat; **Temperature Process:** Cold-Holding

Location: Freezer at 11 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

GREEN LAKES HOMES
Minneapolis
County/Group: Anoka County

Inspection Info

Report Number: F1013261044
Inspection Type: Full
Date: 7/27/2026
Time: 01:00 pm

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39808016-0	Date: July 27, 2026
Facility Name: Green Lakes Homes	
Facility Address: 11540 Norway Street NW, Coon Rapids, MN 55448	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Pattern

TIME PERIOD OF CORRECTION: Immediate

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: In occupied resident bedroom five, the egress window and window opening hardware were obstructed by the placement of personal items in front of the window. Improper storage would delay exiting through an egress window in the event of an emergency.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments:

- On the covered deck at the back of the building, a power strip was plugged into an extension cord and used to supply power to personal electronics.
- A green extension cord was used to supply power to the refrigerator in the basement storage room.

4. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: A battery operated smoke alarm had been installed over an electrical junction box with capped wires on the ceiling in occupied resident bedroom four.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Two (2) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: There was an empty smoke alarm bracket on the ceiling in occupied resident bedroom four. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not know this alarm had been removed. The smoke alarm was reinstalled while the surveyor was onsite.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguisher mounted on the wall in the kitchen was lacking an annual maintenance tag from certified service personnel.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

- A glass window pane in occupied resident bedroom two was cracked on the back of the building
 - There was an active hornet nest outside the egress window in occupied resident bedroom four.
 - The door for the shared bathroom in the basement did not latch when closed.
 - There was a hole in the door for occupied resident bedroom two.
 - One floor tile was missing in the kitchen.
-

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building and environmental factors. Third party templates were used that inaccurately directed employees to use pull fire alarms, to evacuate through adjacent smoke compartments, and to utilize smoke doors. The plan inappropriately directed employees that in the case of a large scale fire, the local fire department may order evacuation of the facility in a building without fire resistant construction and life safety systems.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop site specific instructions for residents on the proper actions to take in the event of a fire. Additionally, there were no written procedures for use of emergency escape and rescue openings (egress windows) in resident bedrooms.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The provided fire safety and evacuation plan (FSEP) failed to include evacuation procedures for the individualized unique needs of residents. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated these procedures were included in the emergency evacuation reports and that these reports were maintained electronically. These procedures would not be easily accessible to all staff and emergency responders during a fire or similar emergency.