



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 23, 2026

Licensee

Harmony Homes LLC

7006 Morgan Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL36862016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environmentt - \$1,000.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environmentt - \$1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environmentt - \$1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Servicest - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$5,000.00**. 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.

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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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Harmony Homes LLC. Please contact Jess Schoenecker, Supervisor, at 651-201-3789 **on or before Tuesday, June 28, 2026**, to schedule the conference call.

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/Bm5uQEPhVa>**. 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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36862	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER HARMONY HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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: SL36862016-0 On June 23, 2026, through June 25, 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 four (4) residents; four receiving services under the Assisted Living Facility license. On June 23, 2026, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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.		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. 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: The licensee's Staff Listing with an as of date June 23, 2026, indicated unlicensed personnel (ULP)-B, ULP-C, and ULP-E were hired to provide assisted living services on July 8, 2025, November 21, 2024, and September 18, 2025, respectively. On June 24, 2026, at 10:41 a.m., ULP-C retrieved a pre-filled medication box from a locked cabinet and went to the appropriate day and time and	0 330			

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0 330	Continued From page 2 poured the six (6) pills into a medication cup and gave them to R1. R1 picked three (3) to take and asked to take the rest after he ate. ULP-C did not reference R1's medication administration record (MAR) during the medication administration. On June 24, 2026, at 11:45 a.m., ULP-C and clinical nurse supervisor (CNS)-A were sitting near each other. The surveyor asked if staff were trained on medication setup for unplanned leave of absence, CNS-A stated all staff completed training "via Zoom" and stated the form should be in Residex (electronic health record) to fill out, bag or use the pill organizer. CNS-A stated that training was completed "approximately a year ago," a verbal demonstration was completed at that time. The surveyor requested documentation of that training. CNS-A then stated for newer hires, she would need to start training staff during orientation. ULP-C remained silent during this interview and did not confirm she attended this Zoom meeting. On June 24, 2026, at 3:59 p.m., via email, an identified person provided a typed and unsigned document titled "[Licensee name] Employee Meeting" dated November 9, 2024, at 2:00 p.m., indicated eight employees including ULP-B, ULP-C, and ULP-E attended the meeting "via Whattsapp (sic) zoom call." The document indicated away medication was discussed with staff and a tutorial was provided. ULP-C's training record lacked documentation of training and competency to provide medication setup for unplanned leave of absence. During exit conference on June 25, 2026, at 2:00 p.m., the surveyor showed CNS-A and owner/licensed assisted living director	0 330			

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0 330	Continued From page 3 (O/LALD)-D the "Employee Meeting" dated November 9, 2024, and asked how ULP-B, ULP-C, and ULP-E were present for this training when according to the licensee's employee list, they were hired after the fact. O/LALD-D stated she "did not know how that happened" or "why that was." CNS-A remained silent. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
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	0 480			

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0 480	Continued From page 4 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 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	0 480			

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0 480	Continued From page 5 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 (FBEIR) dated June 23, 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			
0 680 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	0 680			

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0 680	Continued From page 6 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 interview and record review, the licensee failed to post the emergency preparedness plan (EPP) prominently and failed to review the missing resident plan as required. This had the potential to affect all residents, staff, and visitors during an emergency. 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 June 23, 2026, at 2:05 p.m., environmental engineer from Minnesota Department of Health asked owner/licensed assisted living director (O/LALD)-D where the EPP and evacuation binders were kept. O/LALD-D stated they were locked in the office. On June 25, 2026, at 12:45 p.m., the licensee's EPP last reviewed and updated on March 31, 2026, was retrieved from a locked cabinet near	0 680			

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0 680	Continued From page 7 the front door reviewed with O/LALD-D. O/LALD-D stated they were not aware the missing resident plan required review quarterly and would create a signature page to document reviews and stated the EPP was not posted prominently because it was locked in the office. The licensee's Emergency Preparedness policy dated August 1, 2021, read licensee would post the EPP prominently. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure would be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan would 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			
0 775 SS=I	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	0 775			

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0 775	Continued From page 8 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 780 SS=I	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	0 780			

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0 780	Continued From page 9 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 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, interview, and record review, 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 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).	0 780			

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0 780	Continued From page 10 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=I	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, interview, and record review, 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 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	0 800			

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NAME OF PROVIDER OR SUPPLIER HARMONY HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7006 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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 11 has affected or has 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 June 23, 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=I	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 proper actions to take in the event of a fire to	0 810			

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0 810	Continued From page 12 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, interview, and record review, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twnety One (21) days.	0 810			

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0 950	Continued From page 13	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative on its own separate	0 950			

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0 950	Continued From page 14 page for two of two residents (R1, 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 potential to affect a large portion or all of the residents). The findings include: The licensee converted their comprehensive home care license to an assisted living license on August 1, 2021. On June 23, 2026, at 9:50 a.m., owner/licensed assisted living director (O/LALD)-D stated the licensee had a census of four (4) residents. R1's Assisted Living Contract was signed on May 29, 2025. R2 's Assisted Living Contract was signed on August 1, 2021. R1 and R2's assisted living contracts did not include the required verbatim notice on a document separate from the contract. R1 and R2's unsigned Service Plan (Private)-Addendum to Contract last updated on October 28, 2025, and August 1, 2021, respectively, did include the required verbatim notice. On June 24, 2026, at 3:00 p.m., while reviewing R1 and R2's contract with O/LALD-D, she stated R1's contract was the version being used.	0 950			

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0 950	Continued From page 15 O/LALD-D stated she did not go over the service plans with R1 and R2. The licensee's Notifications policy dated August 1, 2021, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the licensee's liability for health, safety, or personal property for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when	0 970			

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0 970	Continued From page 16 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 and R2's Assisted Living Contract signed on May 29, 2025, and August 1, 2021, respectively, under section "Miscellaneous Provisions 1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee name] upon request. The resident acknowledges that [Licensee name] is not an insurer of the resident's personor (sic) property. The resident agrees that [Licensee name] will not be liable to theresident (sic) for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and tothe (sic) extent that the injury or damage is caused by the negligence of [Licensee name] or its employees or agents. The resident hereby releases [Licensee name] from liability for any personal injury or property damage suffered by the resident ..., unless caused by the negligence of [Licensee name] or its employees or agents." Under section "Indemnification: [Licensee name] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee name] harmless from any claims or damages unless caused solely by negligence of [Licensee name]."	0 970			

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0 970	Continued From page 17 During interview on June 24, 2026, at 3:00 p.m., owner/licensed assisted living director (O/LALD)-D stated R1 and R2's contracts were the current version in use for all residents and was not aware there was a waiver of liability within the contract. The licensee's Notifications policy dated August 1, 2021, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640			

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01640	Continued From page 18 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a resident or resident representative's signature to document agreement on the services on service plan when changes were made to the services for two of two residents (R1, R2). 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: During observation between June 23, 2026, through June 25, 2026, at various times, the surveyor observed meal preparation for R1 and R2. Unlicensed personnel (ULP)-C provided R1 with medication administration, transfer assistance using a transfer board, and toileting assistance. R1 R1 was admitted for assisted living services on May 29, 2025, and had diagnoses including neurogenic bladder, muscle weakness, and	01640			

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01640	Continued From page 19 paraplegia. R1's Service Plan (Private) - Addendum to Contract with effective date (print date) of June 24, 2026, unsigned, indicated R1 received services for appointment assistance, bathing assistance shower or bath, meal tray, dressing, grooming, laundry, incontinence care, manage behavior for anxiety and depression, medication administration, bedmaking, record vital signs, safety checks, housekeeping, and registered nurse (RN) visits. R2 R2 was admitted for comprehensive services on March 10, 2021, and began assisted living services on August 1, 2021. R2 had diagnoses including schizophrenia, anxiety, high blood pressure, and chronic obstructive pulmonary disease (COPD). R2's initial service plan signed on March 10, 2021, indicated R2 received medication reminders as needed, hygiene/grooming assistance reminder, personal laundry, housekeeping, food preparation, and managing anxiety. R2's Service Plan (Waiver) - Addendum to Contract with effective date of August 1, 2021, unsigned, indicated R2 received services for appointment assistance, meal tray, dressing, manage behavior for agitation, repetitive behavior, self-isolation, other mental health need, and anxiety, medication administration, record vital signs, safety checks, symptom screening 1, and RN visit. R1 and R2's medical records lacked a signed service plan indicating agreement between the	01640			

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01640	Continued From page 20 resident or resident's representative and a representative from the licensee. On June 24, 2026, at 10:35 a.m., clinical nurse supervisor (CNS)-A provided R1's unsigned service agreement and stated she would go over the service plan with R1 and have him sign it. The surveyor asked why R1 and R2's service plans were not signed, CNS-A stated usually owner/licensed assisted living director (O/LALD)-D viewed the service plans with the residents and had them sign it. On June 24, 2026, at 3:00 p.m., O/LALD-D stated she did not review R1 and R2's current service plans with R1 and R2. The licensee's Service Plan policy dated August 1, 2021, indicated an individualized service plan was implemented for all residents. The initial service plan and any revisions would be signed by a representative from licensee and the resident or resident's representative, indicating agreement with the services that would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	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	01730			

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01730	Continued From page 21 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 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.	01730			

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01730	Continued From page 22 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 (IMMP) to include all required content for one of two residents (R1). 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: R1 had diagnoses including neurogenic bladder, paraplegia (paralysis of lower extremities), muscle weakness. R1's unsigned Service Plan (Private)- Addendum to Contract with effective date June 24, 2026, indicated R1's services included assistance with medication administration. R1's provider orders dated June 17, 2026, ordered hydrocortisone 2.5% topical cream (for inflammation), apply to affected area twice daily and bisacodyl 10 milligram (mg) suppository (stimulant laxative). R1's Med Admin Summary-Actual-Month dated June 1-30, 2026, indicated the following: -Procto-Med Hydrocortisone 2.5%, apply topically to the affected area twice a day as directed; and -bisacodyl 10 mg suppository, insert 1	01730			

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01730	Continued From page 23 suppository rectally as needed. R1 to self-administer the suppository every other day. On June 24, 2026, at 10:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer pills (R1 took three (3) of six (6) pills) from the AM (morning) slot under Wednesday within the pill organizer. R1 stated he would take the remaining pills after he ate. On June 24, 2026, at 11:32 a.m., R1 requested the remaining pills so ULP-C provided them with water. About six minutes later, ULP-C logged into the electronic MAR and documented on the six pills. The surveyor observed ULP-C click administered under hydrocortisone cream. The surveyor asked if the hydrocortisone was administered, ULP-C stated R1 administered it himself. The MAR did not indicate it was self-administered. On June 24, 2026, at 3:30 p.m., the surveyor asked R1 if the hydrocortisone was located within his room. R1 pulled out a nearly empty tube of hydrocortisone and showed it to the surveyor. R1 stated he administered it himself. Then the surveyor observed a box of hydrocortisone (brand new) in the locked medication cabinet with the rest of his medications. R1's IMMP included the following: -R1 was able to self-administer suppositories; and -all medications were locked and secured in the medication cabinet and key is kept on the staff at all times. R1's IMMP lacked the following: -a description how bisacodyl and hydrocortisone cream would be stored; and	01730			

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01730	Continued From page 24 - documentation of specific resident instructions relating to the administration of medications. On June 25, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated she assessed R1 was able to keep the bisacodyl and hydrocortisone cream within his personal area and the IMMP was missing instruction on where the bisacodyl and hydrocortisone cream would be stored. CNS-A stated she updated the MAR to show hydrocortisone cream was self-administered. The licensee's Assessment of Medications policy dated August 1, 2021, indicated the registered nurse would document an individualized medication management plan to include description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction and documentation procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750			

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01750	Continued From page 25 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS)-A instructed one of one unlicensed personnel ((ULP)-C) in the proper methods to administer medications from a pill organizer box. 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: On June 24, 2026, at 10:41 a.m., the surveyor observed ULP-C pull a pill organizer box from a locked metal cabinet and opened the AM slot under Wednesday and poured the pills into a medication cup. ULP-C brought the medication cup to R1 without referencing the medication administration record (MAR) and R1 took three (3) of six (6) pills. R1 stated he would take the remaining pills after he ate. ULP-C placed the remaining pills in the cabinet and went to the kitchen to prepare R1's breakfast. On June 24, 2026, at 11:32 a.m., R1 requested the remaining pills so ULP-C provided them with water. Approximately six minutes later, ULP-C logged into the MAR and documented the	01750			

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01750	Continued From page 26 administration of the six pills. The MAR did not have a physical description of each pill to correlate to what was in the pill organizer box. The surveyor asked ULP-C if she would have a way of knowing what was being given and if it was correct, ULP-C stated she did not know what she was giving and did not count the number of pills against the MAR. ULP-C stated at another job, they would check the six rights of medication administration when punching pills out of bubble packs. ULP-C stated if the resident questioned anything, she would contact the nurse for further directions. ULP-C's 2.30 Medication Administration-Oral Meds Competency dated November 23, 2024, indicated CNS-A observed ULP-C check the MAR, gather medications, and follow facility protocol for administering medication (medications may be in medication cart, cabinets, or in pre-filled dosage boxes. The competency also indicated ULP-C was competent by checking the six rights of medication administration by checking right resident, right medication, right date, right time, right route, and right dose. On June 25, 2026, at 1:24 p.m., CNS-A stated during medication training and observing medication administration demonstration, she ensured the staff knew how to check the six rights of medication administration, what the procedures were for PRNs, explained the pill organizer box and showed where they would go on the MAR to verify medications. The surveyor asked how the ULP could verify the medications given if the pills were in the pill organizer box and the MAR did not include physical descriptions, CNS-A stated based on the discussion the day prior, she would have staff count the number of pills to compare. CNS-A stated the licensee did	01750			

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01750	Continued From page 27 not have protocol for administering medications from pre-filled pill organizer boxes. The licensee's Medication Administration policy dated August 1, 2021, indicated the registered nurse (RN) could delegate medication administration to a ULP if they have passed a competency evaluation with respect to all medication routes to be administered and the RN has prepared written instructions for the ULP in the proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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	01760			

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01760	Continued From page 28 review, the licensee failed to document why the medication was not administered as prescribed and failed to transcribe orders correctly for two of two residents (R1, R2) who received medication management services. 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: During the entrance conference on June 23, 2026, at 10:19 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication setup by the registered nurse (RN) and medication administration to licensee's four (4) residents. R1 R1 had diagnoses including neurogenic bladder, paraplegia (paralysis of lower extremities), muscle weakness. R1's unsigned Service Plan (Private)- Addendum to Contract with effective date June 24, 2026, indicated R1's services included assistance with medication administration and weekly RN visit. R1's Med Admin Summary - Actual - Month (medication administration record-MAR) dated June 1-23, 2026, indicated R1 received the following medication: -atorvastatin calcium 10 milligram (mg), give 10	01760			

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01760	Continued From page 29 mg by mouth at bedtime for high cholesterol; -baclofen 20 mg, one tablet 4 times per day for muscle spasm; -dicyclomine 10 mg, one capsule by mouth two times per day before meal (treats irritable bowel syndrome); -docusate sodium 100 mg, give one capsule by mouth daily (softens stool); -doxepin hydrochloride 10 mg, give 10 mg orally at bedtime for depression; -esomeprazole magnesium 40 mg, one capsule daily before a meal (treats acid reflux); -fosfomycin tromethamine 3 grams, one packet every 72 hours for 3 doses (antibiotic); -gabapentin 300 mg, give one capsule orally three times a day for pain; -hydrocortisone 2.5% topical cream-apply topically to affected area twice daily (skin irritation); -oxybutynin extended release (ER) 15 mg, give 15 mg by mouth one once daily (to reduce bladder spasm); -Pepcid 20 mg, give one tablet by mouth twice daily for 30 days (to treat heartburn); -senna 8.6 mg, give one tablet by mouth every evening (for constipation); and -sulfamethoxazole and trimethoprim (for urinary tract infections) 800-160 mg, one tablet twice daily for 10 days. R2 R2 had diagnoses including schizophrenia, anxiety, high blood pressure, and chronic obstructive pulmonary disease (COPD). R2's unsigned Service Plan (Private)- Addendum to Contract with effective date August 1, 2021, indicated R2's services included assistance with medication administration and weekly RN visit.	01760			

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01760	Continued From page 30 R2's prescriber orders dated November 19, 2025, ordered the following medication: -amlodipine 5 mg, one tablet daily for blood pressure; -loratadine 10 mg, one tablet daily as needed (PRN) for allergies; and -naproxen 250 mg, one table by mouth twice daily for pain. DOCUMENTATION ERRORS R1's MAR dated June 1-23, 2026, indicated R1 received medications four times daily at 9:00 a.m., 2:00 p.m., 8:00 p.m., and 2:00 a.m. The MAR lacked the following documentation (blank boxes): -baclofen- at 2:00 a.m. (23 of 23 days), at 8:00 a.m. (2 out of 23 days), at 2:00 p.m. (10 out of 22 days), and at 8:00 p.m. (1 out of 22 days); -dicyclomine- at 8:00 a.m. (2 out of 23 days), and at 2:00 p.m. (10 out of 22 days); -esomeprazole magnesium- at 8:00 a.m. (2 out of 23 days); -gabapentin- at 8:00 a.m. (2 out of 23 days), at 2:00 p.m. (10 out of 22 days), and at 8:00 p.m. (1 out of 22 days); -oxybutynin- at 8:00 a.m. (2 out of 23 days); -hydrocortisone cream- at 8:00 a.m. (2 out of 23 days, and at 8:00 p.m. (1 out of 22 days); -sulfamethoxazole and trimethoprim scheduled twice daily for 10 days only- at 8:00 a.m. (1 out of 14 days-should have been only 10 days), and 8:00 p.m. (0 out of 15 days-should have been only 10 days); -fosfomycin tromethamine- at 2:00 p.m. (1 out of 2 days); -atorvastatin- at 8:00 p.m. (1 out of 7 days); -docusate sodium- at 8:00 p.m. (1 out of 22 days); -doxepin hydrochloride- at 8:00 p.m. (1 out of 22 days); and	01760			

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01760	Continued From page 31 -senna- at 8:00 p.m. (1 out of 22 days). R2's Med Admin Summary - Actual - Month dated June 1-24, 2026, indicated R2 received medications twice daily at morning time (AM) and overnight. The MAR lacked the following documentation (blanks boxes): -amlodipine- AM (4 out of 24 days); -loratadine- AM (4 out of 24 days); -naproxen- AM (4 out of 24 days), and overnight (7 out of 24 days); and -tab-a-vite- AM (4 out of 24 days). On June 24, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated R1's medications were not given on June 16, 2026, and the MAR lacked documented explanation why they were not given. On June 25, 2026, at 11:10 a.m., unlicensed personnel (ULP)-B stated he could not recall if he worked June 4, 2026, but stated he occasionally observed 2:00 p.m. medications within R1's pill organizer box not given but for the morning and bedtime medications, they were usually given. Regarding the MAR, ULP-B stated if they did not document the medication administration within a period of time, the MAR locked them out. ULP-B stated blank boxes on the MAR could mean that either the medication administration documentation was missed or it was not administered by staff. TRANSCRIPTION OF ORDERS R1's medication list received from the clinic on June 24, 2026, indicated the following changes: -dicyclomine 20 mg, one tablet four (4) times a day by mouth for 30 days prescribed on June 17, 2026 (MAR indicated 10 mg two times day with a note indicated it was prescribed three times a day but R1 preferred to take twice daily); and	01760			

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01760	Continued From page 32 -oxybutynin chloride ER 10 mg, one tablet by mouth every day (MAR indicated 15 mg once daily). On June 24, 2026, at 2:40 p.m., the surveyor and owner/licensed assisted living director (O/LALD)-D visualized the bottle of oxybutynin 10 milligram (mg) then looked at the pill organizer box and saw one tablet was set up. O/LALD-D verified one tablet of oxybutynin 10 mg was set up daily. On June 25, 2026, 11:20 a.m., O/LALD-D checked the staff schedule and confirmed ULP-B (morning shift) and ULP-C (evening shift) both worked June 4, 2026. ULP-C stated they were confident that the medications were administered to R1 that day but could not explain why it was not documented on the MAR. O/LALD-D stated when residents leave the facility, the staff document in the notes. CNS-A stated she could not recall when the oxybutynin dose was changed from 15 mg to 10 mg. On June 25, 2026, at 11:50 a.m., the surveyor asked ULP-B to open the medicine cabinet and observed the dicyclomine 10 mg bottle. CNS-A stated she was informed that day that R1's provider increased dicyclomine from 10 mg to 20 mg four times daily. CNS-A stated the pharmacist did not receive the electronic prescription until June 19, 2026, and that the medications had not been delivered yet. CNS-A stated R1's clinic appointment was on June 16, 2026. On June 25, 2026, at 1:20 p.m., CNS-A stated the oxybutynin dose on the MAR was incorrect and failed to update the dose, but had been setting up the dose as prescribed.	01760			

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01760	Continued From page 33 The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by licensee's staff would be documented in the resident's clinical record. If the administration of one or more medications were not completed, staff would document the following: -the reason why the medication was not administered; -follow up procedures to meet the resident's needs in compliance with the medication management plan; -appropriate notification to registered nurse (RN) supervisor or other person as instructed regarding missed dosages; and -medication error report, if appropriate. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the RN was responsible for implementing medication orders or for delegating the orders to the appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	01770			

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01770	Continued From page 34 Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2). Also, the licensee failed to accurately document medication setup for R1. 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: During entrance conference on June 23, 2026, at 10:19 a.m., clinical nurse supervisor (CNS)-A stated all residents received weekly medication setups by the registered nurse (RN) every Monday. R1 R1 was admitted on May 29, 2025, and began receiving assisted living services. R1's unsigned Service Plan (Private)- Addendum to Contract with effective date June 24, 2026, indicated R1's services included assistance with medication administration and weekly RN visit. On June 24, 2026, at 2:40 p.m., the surveyor and owner/licensed assisted living director (O/LALD)-D observed R1's pill organizer which included four (4) slots under each day of the week that included 2:00 a.m. slot which was	01770			

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01770	Continued From page 35 empty. R1's Med (medication) Setup/Review Summary-Month from June 2, 2026, through June 8, 2026, lacked documentation by the RN to include: -dates of medication setup, -name of medication, -quantity of dose, -times to be administered, -route of administration, and -name of person completing medication setup. The record also included documentation of medication setup by CNS-A on June 1, and 8-29, 2026, for bisacodyl (self-administered for constipation) and simethicone (for flatulence) which was an as needed medication. R2 R2 was admitted on March 10, 2021, and began receiving assisted living services on August 1, 2021. R2's unsigned Service Plan (Private)- Addendum to Contract with effective date August 1, 2021, indicated R2's services included assistance with medication administration and weekly RN visit. R2's Med Setup/Review Summary-Month from June 2, 2026, through June 7, 2026, lacked documentation by the RN to include: -dates of medication setup, -name of medication, -quantity of dose, -times to be administered, -route of administration, and -name of person completing medication setup. During interview on June 24, 2026, at 12:21 p.m., after reviewing the R1's medication setup	01770			

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01770	Continued From page 36 documentation, CNS-A explained the days she missed documenting the medication setup, the unlicensed personnel (ULP) staff would have to click "set up" on R1's electronic health record which documented ULP's initials during that time. CNS-A stated she set up the medications that week but forgot to document the task. Regarding the 2:00 a.m. baclofen, CNS-A did not setup the medication because R1 had been refusing it but accidentally documented they were set up. CNS-A also acknowledged she documented she set up hydrocortisone cream and bisacodyl when the medications were "self-administered." The licensee's Medication Documentation policy dated August 1, 2021, indicated documentation would be complete, accurate, and legible. The licensee would document medication set up according to the following: -date of medication setup; -name of medication; -quantity of dose; -times to be administered; -route of administration; and -name/title of person completing medication setup. Documentation of medication set up would be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790			

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01790	Continued From page 37 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36862	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2026
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01790	Continued From page 38 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) had provided training and ensured the unlicensed personnel (ULP) demonstrated competency to provide medications for residents having unplanned time away when the licensed nurse was not available for three of three employees (ULP-B, ULP-C, ULP-E). This had the potential to affect all residents who would need medications for an unplanned time away. 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).	01790			

Minnesota Department of Health

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01790	Continued From page 39 The findings include: During entrance conference on June 23, 2026, at 10:19 a.m., owner/licensed assisted living director (O/LALD)-D and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents. On June 24, 2026, at 10:41 a.m., ULP-C retrieved a pre-filled medication box from a locked cabinet and went to the appropriate day and time and poured the six (6) pills into a medication cup and gave them to R1. R1 picked three (3) to take and asked to take the rest after he ate. ULP-C did not reference R1's medication administration record (MAR) during the medication administration. The licensee's Staff Listing with as of date June 23, 2026, indicated ULP-B, ULP-C, and ULP-E were hired to provide assisted living services on July 8, 2025, November 21, 2024, and September 18, 2025, respectively. On June 24, 2026, at 11:45 a.m., ULP-C and clinical nurse supervisor (CNS)-A were sitting near each other. The surveyor asked if staff were trained on medication setup for unplanned leave of absence, CNS-A stated all staff completed training "via Zoom" and stated the form should be in Residex (electronic health record) to fill out, bag or use the pill organizer. CNS-A stated that training was completed "approximately a year ago," a verbal demonstration was completed at that time. The surveyor requested documentation of that training. CNS-A then stated for newer hires, she would need to start training staff during orientation. ULP-C remained silent during this interview and did not confirm she attended this Zoom meeting.	01790			

Minnesota Department of Health

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01790	Continued From page 40 On June 24, 2026, at 3:59 p.m., via email, an identified person provided a typed and unsigned document titled "[Licensee name] Employee Meeting" dated November 9, 2024, at 2:00 p.m., indicated eight employees including ULP-B, ULP-C, and ULP-E attended the meeting "via Whattsapp (sic) zoom call." The document indicated away medication was discussed with staff and a tutorial was provided. ULP-C's training record included oral medication competency completed on November 23, 2024, but lacked documentation of training and competency to setup medications for unplanned leave of absence. During exit conference on June 25, 2026, at 2:00 p.m., the surveyor showed CNS-A and owner/licensed assisted living director (O/LALD)-D the "Employee Meeting" dated November 9, 2024, and asked how ULP-B, ULP-C, and ULP-E were present for this training when according to the licensee's employee list, they were hired after the fact. O/LALD-D stated she "did not know how that happened" or "why that was." CNS-A remained silent. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records would include training and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			

Minnesota Department of Health

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01820	Continued From page 41	01820			
01820 SS=D	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 observation, interview, and record review, the licensee failed to obtain current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, when one of one resident (R1) requested medications not to be given as prescribed. 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: On June 24, 2026, at 10:41 a.m., the surveyor observed unlicensed personnel (ULP)-C pull out a pill organizer box for R1 and administer three of six morning pills (per R1's request). The surveyor observed the bottom row labeled "2AM" which did not contain any medication. R1 had diagnoses including neurogenic bladder, paraplegia (paralysis of lower extremities), and muscle weakness.	01820			

Minnesota Department of Health

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01820	Continued From page 42 R1's unsigned Service Plan (Private)- Addendum to Contract with effective date June 24, 2026, indicated R1's services included assistance with medication administration and weekly RN visits. R1's Med Admin Summary - Actual - Month (medication administration record-MAR) dated June 1-23, 2026, indicated R1 received the following medications: -baclofen 20 milligrams (mg), one (1) tablet four times per day (2:00 a.m., 8:00 a.m., 2:00 p.m., and 8:00 p.m.) for muscle spasm. The MAR indicated R1 did not receive 2:00 a.m. dose between June 1-23, 2026; -dicyclomine 10 mg, one (1) capsule by mouth two times per day before meal (treats irritable bowel syndrome). The MAR included the following notation: "The order for medication is 3 times daily, but resident wants to take only 2 times in the morning before breakfast and in the afternoon before lunch;" and -senna 8.6 mg, give one (1) tablet by mouth every evening (for constipation). The MAR included the following notation: "Resident refused to take 2 two (sic) tablets, but he prefers to take only one tablets (sic) at night." R1's medication list received from the clinic on June 24, 2026, indicated the following orders: -baclofen 20 mg, one (1) tablet by mouth four times daily. -dicyclomine 20 mg, one (1) tablet four times a day by mouth for 30 days prescribed on June 17, 2026 (MAR indicated 10 mg two times day with a note indicating it was prescribed three times a day but R1 preferred to take it twice daily); and -senna 8.6 mg, one (1) tablet by mouth in the morning and two (2) tablets by mouth in the evening.	01820			

Minnesota Department of Health

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01820	Continued From page 43 On June 24, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated R1 had been refusing the 2:00 a.m. baclofen for a while and had not been setting them up in the pill organizer box. When asked if R1's provider had been informed, CNS-A stated she would let the provider know and get a new order. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber would be obtained for all medications with which the licensee assists residents, including over-the-counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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 review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with hospital side 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	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

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02310	Continued From page 44 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: During facility tour on June 23, 2026, at 11:15 a.m., while R1 was sitting in his power wheelchair in the living room, upon permission from R1, the surveyor and clinical nurse supervisor (CNS)-A observed R1's hospital-style bed with raised upper half side rails on both sides. Side rails on both sides were secured to the frame but left rail (rail facing center of room) moved away from the bed frame slightly when the surveyor pulled on it while assessing for stability. The surveyor asked CNS-A if they completed side rail assessments including measurements, CNS-A stated "no." CNS-A stated they had not been made aware of any issues related to side rails. R1 was admitted for assisted living services on May 29, 2025, and had diagnoses including neurogenic bladder, muscle weakness, and paraplegia. R1's Master Care Plan updated June 7, 2026, indicated R1 received services including assistance with medication management, showers, transfers, toileting, and bed mobility. R1's Assessment dated June 7, 2026, identified R1 used an electric bed. The assessment lacked identification R1 used bilateral side rails. R1's record lacked the following required content: -purpose and intention of the side rail -resident's side rail use/need assessment	02310			

Minnesota Department of Health

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02310	Continued From page 45 -physical inspection of side rail and mattress for areas of entrapment, stability, and correct installation; -specific measurements of zones of entrapment; -indication if the side rails were Food and Drug Administration (FDA) compliant; and -documentation that education including alternatives and risk versus benefits were discussed with the resident or responsible party. During interview on June 23, 2026, at 1:15 p.m., CNS-A and owner/licensed assisted living director (O/LALD)-D confirmed R1 was admitted to the facility with the electric bed and both side rails. O/LALD-D stated they provided R1 with a brochure regarding side rail safety upon admission. CNS-A stated they were not aware of entrapment zone measurements and assessing the need and use of side rails. When the surveyor asked if their electronic health record (Residex) asked about side rails, would it produce a side rail assessment, CNS-A stated "yes," but "must have skipped over it." During interview on June 23, 2026, at 1:30 p.m., unlicensed personnel (ULP)-B stated R1 used the side rails while rolling to the side in bed but did not use the side rail during transfers out of bed. The licensee's Side Rail Use policy dated August 1, 2021, indicated the following actions would be taken when a resident is utilizing side rails: -registered nurse (RN) would assess for level of mobility, including bed mobility, level of consciousness, level of cognition, presence of orthostatic hypotension, and vision; -educate the resident, and responsible party when appropriate, alternatives to the use of side rails; -RN would document the purpose of the side rails	02310			

Minnesota Department of Health

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02310	Continued From page 46 and the education provided; -the resident, resident's legal representative or resident's designated representative would co-sign the document agreeing to the benefits and risks of the side rails; and -verify the side rail is of a safe design, properly maintained, and use is consistent with manufacturer recommendations. The FDA's, A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health's (MDH) Assisted Living: Resources and FAQ's website updated April 17, 2026, read under Bed Rails, documentation about a resident's bed rails includes, but is not limited to: -an assessment was completed; -measurements were completed and documented; -the rails were FDA compliant; -and the risk vs. benefits were discussed and documented with the resident/responsible party. No further information was provided.	02310			

Minnesota Department of Health

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02310	Continued From page 47 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

Harmony Homes LLC
7006 MORGAN AVENUE NORTH
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36862

Risk:
License:
Expires on:
CFPM: Abdulatif K. Dire
CFPM #: FM121090; Exp: 1/27/2027

Inspection Info

Report Number: F1047261163
Inspection Type: Full - Single
Date: 6/23/2026 Time: 12:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW EGGS IN REFRIGERATOR STORED ON SHELF ABOVE READY TO EAT FOODS SUCH AS JUICE, CONDIMENTS, ETC. CORRECTED ON SITE- EGGS LOCATED TO LOWER SHELF.

Comply By: 6/23/2026 Originally Issued On: 6/23/2026

New Order: 3-500A Microbial Control: cooling

3-501.13ABC Priority Level: Priority 3 CFP#: 35

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

COMMENT: FROZEN MEATS OBSERVED THAWING IN PAN ON THE COUNTER. CORRECTED ON SITE- PAN WAS RELOCATED UNDER RUNNING WATER, AND THEN RELOCATED TO REFRIGERATION TO FINISH THAWING.

Comply By: 6/23/2026 Originally Issued On: 6/23/2026

New Order: 4-300 Equipment Numbers and Capacities

4-301.12A Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

COMMENT: REPEAT ORDER- FIRST ISSUED 5/28/24

FACILITY DOES NOT HAVE A 3 COMP SINK OR A DISHWASHER WITH A SANITIZING FUNCTION. FACILITY IS USING ADDITIONAL BASINS FOR SANITIZING. FACILITY SHOULD USE BASINS BUT NEEDS PERMANENTLY PLUMBED DISHWASHING EQUIPMENT.

Comply By: 9/23/2026 Originally Issued On: 6/23/2026

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: DISH LOCATED IN HANDWASHING SINK BASIN. CORRECTED ON SITE- DISH WAS RELOCATED. DISCUSSED NEED TO KEEP SINK FREE OF DISHES AND USE THAT BASIN ONLY FOR HANDWASHING.

Comply By: 6/23/2026 Originally Issued On: 6/23/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator A. Bohnen.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, vinyl floor, painted walls, solid counter top, and a painted ceiling.

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

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, 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 F1047261163 from 6/23/2026

Abshiro Tobe
Operator



Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@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

Harmony Homes LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1047261163
Inspection Type: Full
Date: 6/23/2026
Time: 12:00 pm

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

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36862016	Date: 6/23/2026
Facility Name: Harmony Homes LLC	
Facility Address: 7006 Morgan Ave N, Minneapolis, MN 55430	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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. Exit signs shall be always illuminated. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.6.3] The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

Comments: The exit signs installed in the facility did not function when tested. The exit signs also had emergency lighting which failed to illuminate when tested. If exit signage and emergency lighting are installed, they should be maintained with required operable backup power.

3. Gas containers shall not be stored inside of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 603.4.2.3.4]
- Comments: A 20-pound tank full of propane was stored in a closet next to the front entry door. Propane tanks should not be stored in the living area of the building and should be stored appropriately.*
4. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: An unapproved multiplug adapter was in use in resident room 1 to power a small fridge and other electronics. Unapproved multiplug adapters should be removed.

5. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its

presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments:

The egress window well connected to resident room 3 had plants growing in it which obstructed the egress window from readily opening. The vegetation should be removed, and the egress well should be kept clear of obstruction.

The egress window well connected to resident room 4 had plants growing in it and a significant amount of trash which obstructed the egress window from readily opening. The vegetation should be removed, the trash should be cleaned up, and the egress well should be kept clear of obstruction.

The window crank for the egress window in resident room 4 was not functioning properly and it was difficult to open the window. The window crank should be repaired and the window maintained in proper working order.

The hallway outside of resident room 4 had a significant number of items stored which obstructed egress from the room. Furniture, dolls, papers, car tires, skis, and other various items were stored in the hallway which limited the ability to exit from the resident room.

6. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: The ventilation connected to the dryer was not properly attached and a significant amount of lint had accumulated behind the dryer. The dryer ventilation should be maintained in good working order and the excess lint removed to avoid a fire hazard.

7. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: A lock was installed at the top of the stairs to the basement that was only readily openable from the ingress side. The lock was not operable when tested and the door did not lock, but the hardware should be removed, and the door should be maintained without unapproved locks which may prevent egress.

8. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached

bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: Appropriate carbon monoxide protection was not provided throughout the facility. Most resident rooms did not have carbon monoxide detection present. The carbon monoxide detector in the lower-level basement did not have any batteries installed and was not functional. Proper carbon monoxide detection should be installed and maintained.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: No smoke alarm was installed in resident room 2 or in resident room 1. Every resident room should be equipped with a functional smoke alarm.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: No smoke alarm was provided outside of resident room 4. Proper smoke alarm coverage should be installed and maintained with smoke alarms outside of each resident room.

3. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: Smoke alarms were not properly interconnected. When tested during the survey the smoke alarms in resident rooms 2, 3 and 4, as well as the upper-level living room failed to connect to any other alarms. Smoke alarms should be interconnected such that the activation of any smoke alarm causes all other smoke alarms in the facility to sound.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 3; Widespread

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:

The electrical outlet in resident room 2 had burn marks which indicated possible electrical issues that threatened fire hazard conditions. The electrical outlets should be repaired and maintained in a state of good repair.

Resident room 4 was not maintained in a safe, clean and sanitary condition. The walls and floors of resident room 4 were dirty and covered with stains and dirt. A significant quantity of dirty dishes, clothes, crumbs, debris, cigarette butts, food waste, and other forms of clutter was present around the room. The carpet, shelves and walls were sullied and not properly maintained. Resident rooms should be kept in a sanitary and clean state and maintained in a state of good repair.

The upper-level bathroom ceiling had peeling and chipping paint. The bathroom ceiling should be maintained in smooth condition and in a state of good repair.

The caulking around the showerhead in the upper-level bathroom was deteriorating and left a gap around the shower head. The area should be restored to and maintained in a state of good repair.

A light bulb was missing from the lighting fixture above the vanity in the upper-level bathroom. The lightbulb should be replaced and the fixture maintained in a state of good repair.

The kitchen floor was worn and had cracks forming between the pieces of flooring. The floor should be maintained in a smooth condition free of cracks and maintained in a state of good repair.

The wall was cut away in a portion of resident room 3 and was left open. The hole in the wall should be repaired, covered and maintained in a state of good repair.

The window assembly for the egress window in resident room 4 was not functional when tested and should be repaired and maintained in a state of good repair.

The light fixture in resident room 4 was missing a protective globe. Light fixtures should have the equipped globes replaced and maintained.

The closet doors in resident room 4 were damaged and not properly connected to the track. The closet doors should be repaired and maintained in a state of good repair.

The light fixture in the lower-level common room was missing a protective globe. Light fixtures should have the equipped globes replaced and maintained.

The light fixture was not properly connected to the ceiling in the laundry room. The light fixture was hanging loose by its wires and should be reconnected and maintained securely attached to the ceiling.

The ramp leading up to the front stairs was deteriorated and had peeling paint and damaged or missing balusters. The ramp should be repaired and maintained in a state of good repair.

The soffit was sagging on the rear side of the house, which left gaps that could allow for animals to access the space. The soffit should be repaired and maintained in a state of good repair.

The exterior of the window frames around the building had peeling paint and signs of deterioration. The window frames should be maintained in a state of good repair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP was stored in a locked office and was not readily accessible during the survey. The FSEP should be stored in a manner where it is readily accessible at all times.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The floor plans provided to the surveyor during survey were not accurate for the facility. The floor plans should be created so that they are accurate and site specific.

3. 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 provide specific fire protection procedures for staff to the surveyor during the survey. The FSEP did not include any site-specific policies for staff procedures during evacuation. Site-specific plans should be included for employees in the FSEP.

4. 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 provide fire protection procedures for residents to the surveyor during the survey. The FSEP did not include any policies for resident procedures during evacuation. Site-specific plans should be included for residents in the FSEP.

5. 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 licensee failed to provide record of unique resident needs for evacuation during a fire or similar emergency. Priority levels were indicated for residents, but no description of those levels was provided and no individual needs were identified. The specific needs of each resident for evacuation should be documented, and those records should be maintained as accurate and up to date.

6. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide adequate record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

7. Residents who are capable of assisting in their own evacuation shall be trained on the 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide record of resident training on the FSEP. Residents should be offered training at least once a year.

8. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee provided fire drill records which indicated all drills conducted in the last year were conducted during the day shift. No further records were located and facility staff indicated that fire drills only occurring during daytime hours. Fire drills should be performed at least twice per shift per year and at least once every other month.