



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

July 24, 2026

Licensee

Jaytee Residential Care LLC

5306 Howe Lane

Brooklyn Center, MN 55429

RE: Provisional Conditional License Number 422403
Health Facility Identification Number (HFID) 42815
Project Number(s) SL42815015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **October 22, 2026**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$500.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Jaytee Residential Care LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Jaytee Residential Care LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** Jaytee Residential Care LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Jaytee Residential Care LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Jaytee Residential Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Jaytee Residential Care LLC will contract with an RN to provide consultation concerning all resident(s) to whom Jaytee Residential Care LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Jaytee Residential Care LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Jaytee Residential Care LLC and MDH must review the RN’s credentials and approve the selection. Jaytee Residential Care LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Jaytee Residential Care LLC in an effort to help Jaytee Residential Care LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Jaytee Residential Care LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Jaytee Residential Care LLC and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:

 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Jaytee Residential Care LLC to correct the violations cited during the survey as well as to determine the overall practice of Jaytee Residential Care LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- g. Corrective Action Plan:** Jaytee Residential Care LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work

- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Jaytee Residential Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Jaytee Residential Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Jaytee Residential Care LLC. If MDH determines Jaytee Residential Care LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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 Jess Schoenecker directly at: 651-201-3789 or email at: Jess.Schoenecker@state.mn.us.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER JAYTEE RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5306 HOWE LANE BROOKLYN CENTER, MN 55429		
(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 SL42815015-0 On June 8, 2026, through June 12, 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 was one (1) resident receiving services under the Provisional Assisted Living Facility license. On June 11, 2026, an immediate correction order was issued for tag identification 0495. 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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-D was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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 the residents). The findings include: Prior to survey initiation on June 8, 2026, at 8:44 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-D currently held a LALD license effective through October 31, 2026; however, LALD-D's license did not list her as the Director of Record for the licensee. On June 8, 2026, at 10:29 a.m., during entrance conference, the surveyor showed administrator/unlicensed personnel (A/ULP)-C that LALD-D was not listed under the licensee in	0 110			

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0 110	Continued From page 2 BELTSS. A/ULP-C stated she would notify LALD-D and have her added. During phone interview on June 11, 2026, at 8:45 a.m., the surveyor asked owner/ULP (O/ULP)-E how LALD-D had been involved in the day to day operation, he explained that LALD-D had been out of the country due to family emergency since end of April and was expected to gone 2-3 months and had not returned yet. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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;	0 480			

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0 480	Continued From page 3 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of 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.	0 480			

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0 480	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 9, 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			
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure that an on-call registered nurse (RN) was available for staff 24 hours a day, seven days per week when clinical nurse supervisor (CNS)-A held a nursing job providing direct patient care at another health care provider. This had the potential to affect the licensee's resident and staff.	0 495	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

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0 495	Continued From page 5 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: On June 8, 2026, at 10:26 a.m., during the entrance conference, CNS-A stated she was the only nurse for the licensee and was available on-call when not on site. CNS-A left the facility shortly after the entrance conference due to personal reasons but said to call if surveyor needed anything. The licensee's Current Resident Roster: State Evaluations dated February 4, 2026, indicated R1 was admitted on February 4, 2026, and received assistance with housekeeping, laundry, meals, medication management, and coordinating transportation. The licensee's current employee list dated March 9, 2026, indicated CNS-A was the only RN employed by the licensee. On June 8, 2026, at 12:19 p.m., the surveyor asked administrator/unlicensed personnel (A/ULP)-C if CNS-A worked at a hospital, A/ULP-C stated CNS-A worked at a nursing home. The surveyor asked what CNS-A's typical schedule was at the nursing home, then owner/ULP (O/ULP)-E entered the room and stated CNS-A sometimes worked overnights but did not know what her schedule was. At 12:40	0 495			

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0 495	Continued From page 6 p.m., the surveyor was then told by O/ULP-E that CNS-A was on-call at a nursing home. On June 9, 2026, at 3:00 p.m., the surveyor contacted CNS-A by phone to set up a time to ask questions regarding the licensee's paperwork, CNS-A stated she could meet with surveyor the next day at 11:00 a.m. On June 10, 2026, at 8:34 a.m., the surveyor received a call from CNS-A stating she could not meet today due to her baby being ill and not having childcare. When the surveyor asked if another day or time worked, CNS-A stated the rest of the week did not work and would need to do it over the phone. A Microsoft Teams meeting (video call) was set up for 12:30 p.m., that day. CNS-A stated she had something scheduled at 2:00 p.m., so the interview was concluded prior to that time. On June 10, 2026, at 2:36 p.m., via email, the surveyor sent CNS-A additional questions that did not get asked during the video interview. On June 10, 2026, at 4:00 p.m., the surveyor texted CNS-A asking if she was available for additional questions since there was no response to the email the surveyor sent earlier. At 4:41 p.m., the surveyor did not receive a response from CNS-A, so an attempt to contact CNS-A would be made the next day. On June 11, 2026, the following events occurred: -at 8:24 a.m., the surveyor sent another text message to CNS-A asking to set up a time to talk over the phone for the remaining questions; -at 8:45 a.m., via telephone, the surveyor spoke with O/ULP-E and stated the surveyor was unable to get ahold of CNS-A, O/ULP-E stated he would	0 495			

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0 495	Continued From page 7 attempt to get in touch with CNS-A; -at 9:45 a.m., the surveyor sent another email with questions; -at 10:37 a.m., via telephone, the surveyor spoke with O/ULP-E and explained the surveyor was still waiting to hear from CNS-A in order to complete the survey; -at 11:37 a.m., via email, CNS-A responded to some questions that were asked then indicated "Sorry I'm at work that's why it took me long"; -at 11:43 a.m., via email, the surveyor sent a final email requesting a response to questions that went unanswered, and asked CNS-A if staff called while she was at work, would she be available; and -at 12:09 p.m., via email, CNS-A indicated the following response "If I'm at work it's really hard to pick up. When I'm not at work yes I will definitely pick up." Then at the end of the email, CNS-A indicated "I'm going back on the floor, u [sic] might not get me." The licensee's undated Facility Staffing Plan completed by CNS-A, indicated on day shift (7:00 a.m.-3:00 p.m.), there would be one direct care staff, one administrator, one house manager, and nurse, then for evening and overnight shifts (3:00 p.m.-11:00 p.m., 11:00 p.m.-7:00 a.m.) there would be one direct care staff, one administrator, one house manager, and nurse (on-call). The licensee's Staffing policy dated August 1, 2021, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs. No further information was provided.	0 495			

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0 495	Continued From page 8 TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (owner/unlicensed personnel (O/ULP)-E, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

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NAME OF PROVIDER OR SUPPLIER JAYTEE RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5306 HOWE LANE BROOKLYN CENTER, MN 55429		
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0 650	Continued From page 9 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: R1's service documentation dated February 2026, indicated O/ULP-E administered R1's medications starting February 6, 2026, and ULP-B administered R1's medications starting February 8, 2026. O/ULP-E On June 9, 2026, at 1:20 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-E demonstrate how he would administer R1's medications. The surveyor observed R1's oral medications. While looking at the paper medication administration record (MAR), the surveyor asked O/ULP-E and administrator/ULP (A/ULP)-C about R1's creams that were listed on the MAR (hydrocortisone, minerin, and urea). O/ULP-E stated R1 self-administered them and R1 kept the creams in his room. O/ULP-E was unable to locate the creams within R1's room and stated R1 may have them on his person. O/ULP-E was hired on February 4, 2026, as an owner and to provide direct care and services to licensee's residents. O/ULP-E's training transcript indicated O/ULP-E completed medication administration training on October 9, 2025, and training on medication administration and vital signs (blood pressure, pulse, respirations, and oxygen level) with clinical	0 650			

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0 650	Continued From page 10 nurse supervisor (CNS)-A on February 17, 2026. O/ULP-E's employee record included oral medication, medication, exercise and treatment reminders, and liquid medication competencies signed by O/ULP-E on February 6, 2026, but lacked an RN attestation that a return demonstration was completed. O/ULP-E's 30 Day Performance Report Form signed by CNS-A on February 27, 2026, was left blank and not signed by O/ULP-E. O/ULP-E's employee record lacked the following required documentation: -competency evaluations for medication administration, medication setup for unplanned leave of absence, and vital signs; -review of provider's policies and procedures, and orientation to each specific resident and services provided; and -registered nurse (RN) supervised O/ULP-E performing a delegated task within 30 days. During interview on June 11, 2026, at 10:37 a.m., O/ULP-E stated he had discussed what to do during an unplanned leave of absence, but did not know if there was documentation of the training. O/ULP-E stated CNS-A had been at the facility observing all staff completing tasks but would need to check with CNS-A about documentation. ULP-B Between June 8 and 9, 2026, at approximately 4:00 p.m., the surveyor observed ULP-B arrive at the facility to work evening shift and provide one-on-one interactions with R1. ULP-B was hired on February 4, 2026, to provide	0 650			

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0 650	Continued From page 11 direct care and services to licensee's residents. ULP-B training transcript indicated ULP-B completed medication administration and vital sign training on February 8, 2026. ULP-B's employee record lacked the following required documentation: -competency evaluations for medication setup for unplanned leave of absence, and vital signs; -review of provider's policies and procedures, and orientation to each specific resident and services provided; and -RN supervised ULP-B performing a delegated task within 30 days. During interview on June 9, 2026, at 3:30 p.m., O/ULP-E showed the surveyor a policy/procedure review acknowledgement sheet and asked the surveyor if they could use the acknowledgement sheet going forward because they had not been documenting review of policies and procedures for all staff. During interview on June 9, 2026, at 4:00 p.m., ULP-B stated she was trained by CNS-A on medication administration, and stated she knew how to set medications up for unplanned leave of absence because R1 left for a few days for an out of state funeral and she sent his medications with him. On June 11, 2026, at 11:37 a.m., via email, CNS-A indicated she completed 30-day supervisions on all staff, but the forms used were not correct forms to use and would be corrected. CNS-A also indicated staff completed vital sign training with her and completed demonstrations on each other.	0 650			

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0 650	Continued From page 12 On June 11, 2026, at 12:09 p.m., via email, CNS-A indicated she had trained staff how to set up medications for unplanned time away and that it was documented. Minnesota Administrative Rules 4659.0190 Training Requirements dated August 11, 2021, read, "Subp. 6. Training records and documentation. A. The facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. B. Documentation of the completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training is completed."	0 650			

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0 650	Continued From page 13 The licensee's Personnel Records policy dated August 1, 2021, indicated employee records would include documentation of orientation, supervision, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and a baseline TB screening that	0 660			

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0 660	Continued From page 14 included a two-step tuberculin (TST) skin test or other evidence of TB testing such as IGRA (a blood test) for two of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). This had the potential to affect all residents, staff, and visitors. 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: TB RISK ASSESSMENT On June 8, 2026, at 3:20 p.m., the licensee provided their current Facility TB Risk Assessment dated February 6, 2026. The assessment documented 2023 incidence of TB data for national, Minnesota, and Hennepin County rates when the 2024 data was readily available on the assessment. The assessment indicated it was completed by CNS-A, and administrator/ULP (A/ULP)-C was responsible for TB infection control in the health care setting, but the person responsible for maintaining TB screening records was left blank. TB SCREENING CNS-A CNS-A was hired on February 4, 2026, to provide supervision and nursing services to the licensee's staff and residents.	0 660			

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0 660	Continued From page 15 CNS-A's employee record included a Baseline TB Screening Tool for Health Care Workers form dated February 4, 2026, and negative blood test completed on September 12, 2023. On June 8, 2026, at 10:26 a.m., CNS-A was at the facility to participate in the entrance conference but soon after left the facility. ULP-B ULP-B was hired on February 4, 2026, to provide direct care and services to licensee's residents. ULP-B's employee record included a Baseline TB Screening Tool for Health Care Workers form dated February 27, 2026, and a negative one-step TST completed on May 16, 2024. On June 8 and 9, 2026, the surveyor observed ULP-B arrive to work evening shift around 4:00 p.m. and began supervising R1. CNS-A and ULP-B's employee records lacked a current TB screening completed within 90 days of hire. During interview on June 9, 2026, at 3:07 p.m., CNS-A stated she did not complete TB screening this year, but could not recall the date of the most recent one completed. During interview on June 9, 2026, at 4:00 p.m., ULP-B stated she completed a TB blood test annually but could not recall when it was last completed. ULP-B said owner/ULP (O/ULP)-E should have the results. During interview on June 10, 2026, at 12:30 p.m., CNS-A stated while running errands, CNS-A	0 660			

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0 660	Continued From page 16 stopped at the facility to review the Facility TB Risk Assessment and signed it. CNS-A stated she did not document the case rates on the form. CNS-A stated she was made aware the licensee was not compliant with their TB screening, so she had planned to get a new TB test completed that week. During interview on June 11, 2026, at 10:03 a.m., A/ULP-C stated both CNS-A and herself completed the TB Risk Assessment by "Googling the 2023 numbers." A/ULP-C was unaware the 2024 case numbers were available on the form itself. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director was responsible for conducting the formal TB Risk Assessment and updating it annually and baseline testing was completed on hire for all direct care providers and anyone who visits residents (including volunteers). The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Either test completed within 90 days of hire was acceptable. Additionally, the Facility Tuberculosis Risk Assessment Instructions and Worksheet for	0 660			

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0 660	Continued From page 17 Health Care Settings Licensed by MDH (derived from above MDH guidelines) updated April 2026, indicated this document was updated annually to reflect current TB case rates and numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan (EPP) prominently. Further, the licensee failed to develop an EPP with all of the required content tailored to the licensee. This had the potential to affect all residents, staff, and visitors. 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: The licensee held a provisional assisted living license issued on October 1, 2025, and set to expire on September 30, 2026. On June 9, 2026, at 3:20 p.m., the surveyor asked administrator/unlicensed personnel (A/ULP)-C where the EPP was located. The surveyor observed A/ULP-C unlock the front closet door with a key and pull out the EPP binder. A/ULP-C stated the EPP was always stored in that closet and stated the required content of Appendix Z was included. The licensee's EPP contained two sections, which included the following: -Disaster Planning and Emergency Preparedness Plan review document signed by licensed assisted living director (LALD)-D on August 1,	0 680			

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0 680	Continued From page 19 2024, that contained procedures for events such as fire, missing client, severe weather/tornado, flood, loss of power, heat stroke, water shortage, and evacuation plan; and -Emergency Operations Plan (EOP) review document approved by A/ULP-C on February 1, 2026, included on page 1-2, critical phone numbers for staff and community profile that listed an entire page of contact information for unrelated licensee and other entities related to that licensee which had no affiliation with current licensee. Throughout the EOP, it indicated the name of the unrelated licensee. During phone interview on June 11, 2026, at 10:03 a.m., A/ULP-C stated both herself and licensed assisted living director (LALD)-D went through the EPP by reviewing it and added fire safety, evacuation, and tornado procedures. A/ULP-C reviewed the "Community Profile" within the EPP and could not explain why an unrelated licensee's information was included. When the surveyor explained to A/ULP-C that the EPP needed to be posted prominently, A/ULP-C stated "Ok." Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan 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 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee	0 680			

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0 680	Continued From page 20 would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also stated the EPP would be prominently posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for one of one resident (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 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:	0 690			

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0 690	Continued From page 21 R1 was admitted to the licensee for assisted living services on February 4, 2026. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. STAFF INITIALS R1's medication administration record (MAR) dated May 1, 2026, through June 8, 2026, indicated multiple staff assisted R2 with medication administration twice daily and as needed. The MAR included staff initials for medication administration that appeared to be those of administrator/unlicensed personnel (A/ULP)-C and initials "DR" for a former employee. R1's service documentation dated May 1, 2026, through June 9, 2026, included multiple staff initials for services provided during day shift (AM) and evening shift (PM). R1's daily progress notes dated May 1-31, 2026, included only staff and registered nurse (RN) initials for each progress note. The above documentation lacked authentication for remaining staff with the full name and title of the person who documented their initials in R1's record. During interview on June 8, 2026, at 2:48 p.m., A/ULP-C stated staff should be signing the back of the MAR but said she knew all of the initials. A/ULP-C stated going forward, she would ensure	0 690			

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(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
0 690	Continued From page 22 staff signed the back of the MAR. RN AUTHENTICATION R1's Medication Management Assessment dated February 12, 2026, included a printed name and title for clinical nurse supervisor (CNS)-A, but lacked authentication by either electronic or printed signature. R1's Abuse Prevention Plan: Vulnerability and Safety Assessment dated February 4, 2026, included a printed name and title for CNS-A, but lacked authentication by either electronic or printed signature. During Microsoft Teams video call on June 10, 2026, at 12:30 p.m., CNS-A was shown R1's Medication Management Assessment and was asked if she completed the assessment, she stated "yes." CNS-A acknowledged it was not authenticated by signing the document. During exit conference on June 12, 2026, at 10:00 a.m., owner/ULP (O/ULP)-E acknowledged R1's record was not authenticated with the name and title of the person making the entry and stated he would begin using an electronic health record program which would require staff log-in. The licensee's Clinical Records policy dated August 1, 2021, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			

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0 800	Continued From page 23	0 800			
0 800 SS=F	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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800			

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0 800	Continued From page 24	0 800			
	TIME PERIOD FOR CORRECTION: Twenty One (21) Days				
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 25 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810			
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900			

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0 900	Continued From page 26 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the Office of Ombudsman for Long-Term Care (OOLTC) with a complete unsigned copy of the assisted living contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that will cause only 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	0 900			

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0 900	Continued From page 27 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held a provisional assisted living license effective October 1, 2025, and set to expire on September 30, 2026. The licensee's Notice of Providing Assisted Living Services (NPALS) indicated they began providing services on February 4, 2026. On June 8, 2026, at 12:55 p.m., during contract review, the surveyor asked owner/unlicensed personnel (O/ULP)-E if a blank contract with all attachments were sent to OOLTC. O/ULP-E stated he recalled providing the Minnesota Department of Health (MDH) with R1's contract and NPALS and recalled sending the NPALS to OOLTC but could not recall if a contract was sent. On June 10, 2026, at 11:35 a.m., via email, a regional ombudsman indicated OOLTC did not receive an unsigned facility contract and encouraged the licensee to send one to the provided email address. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:	0 940			

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0 940	Continued From page 28 (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for two of two residents (R1, R2).	0 940			

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0 940	Continued From page 29 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: R1 R1 was admitted to the licensee on February 4, 2026, and received assisted living services. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. R2 R2 was admitted to the licensee for housing support on November 1, 2025, and discharged on January 15, 2026. R1 and R2's Rental Agreements dated May 3, 2021, and signed on February 4, 2026, and October 29, 2025, respectively, were utilized by the licensee as a contract and lacked the following required information: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;	0 940			

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0 940	Continued From page 30 -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On June 8, 2026, at 1:25 p.m., owner/unlicensed personnel (O/ULP)-E and administrator/ULP (A/ULP)-C stated they could not locate the required content and said they would update the contract to include the missing information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470			

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01470	Continued From page 31 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470			

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01470	Continued From page 32 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of three employees (clinical nurse supervisor (CNS)-A). 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: CNS-A was hired February 4, 2026, to provide clinical oversight and assisted living services.	01470			

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01470	Continued From page 33 CNS-A's employee record included a one hour of infection control which was signed by CNS-A on February 27, 2026, but did not identify the name of the employee who completed the training. CNS-A's Educare transcript (online training program) printed on June 9, 2026, included various trainings completed on November 10-11, 2025. CNS-A's record lacked evidence of the following required orientation topics: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

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01470	Continued From page 34 -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. -orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: -an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; -health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or -information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. During phone interview on June 9, 2026, at 3:07 p.m., CNS-A stated she did not complete any Educare courses through the licensee but did complete dementia training at her other job unrelated to licensee. CNS-A stated administrator/unlicensed personnel (A/ULP)-C trained her fire hazard, where files were located, orientation of the house from what she recalled. The surveyor asked if CNS-A recalled receiving training on assisted living statutes, resident bill of rights, etc., CNS-A stated, "there were a lot of papers, so I cannot remember." The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all employees would complete an orientation on	01470			

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01470	Continued From page 35 topics required by Minnesota statutes and rules for assisted living prior to providing direct care to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of one resident (R1) on or before the admission date.	01610			

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01610	Continued From page 36 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: During entrance conference on June 8, 2026, at 10:26 a.m., clinical nurse supervisor (CNS)-A stated their process for completing nursing assessment included performing head-to-toe assessment and documenting the assessment on their Uniform Assessment Tool (paper), then next assessment was completed within 14 days, and every 90 days. Between June 8 and 9, 2026, at various times, the surveyor observed staff provide supervision, one-on-one interactions, and assist R1 with setting up transportation. R1 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services (DHS) Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. R1's Uniform Assessment Tool (pre-admission assessment) dated February 2, 2026, lacked an assessment on the following:	01610			

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01610	Continued From page 37 -vital signs (temperature, pulse, respiration, blood pressure, oxygen saturation, height, and weight); -summary of health care visits in past 12 months; -personal lifestyle preferences; -psychotropic/antipsychotic use; -depression; -neuro-cognitive; -mental status (incomplete); -elopement; -fall risk; and -assistance with activities of daily living. During Microsoft Teams video interview on June 10, 2026, at approximately 1:15 p.m., CNS-A stated R1's Uniform Assessment Tool was completed on February 2, 2026, but the entire assessment was not completed because it was "confusing and I did not want to put information in there unless I knew," regarding certain topics, but on some of the topics she did ask about it but it was not documented. CNS-A stated she had intended to go back to the assessment and complete it but forgot to. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated an RN would conduct a comprehensive assessment for all residents admitted to licensee to determine the services required and to develop an individualized care plan for staff to implement. The assessment addresses the residents' physical, mental and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			

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01620	Continued From page 38	01620			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620			

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01620	Continued From page 39 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment to include all required content on the uniform assessment tool while completing 14-day, and 90-day assessments for one of one resident (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on June 8, 2026, at 10:26 a.m., clinical nurse supervisor (CNS)-A stated their process for completing nursing assessment included performing head-to-toe assessment and documenting the assessment on their Uniform Assessment Tool (paper), then next	01620			

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01620	Continued From page 40 assessment was completed within 14 days, and every 90 days. Between June 8 and 9, 2026, at various times, the surveyor observed staff provide supervision, one-on-one interactions, and assist R1 with setting up transportation. R1 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services (DHS) Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. R1's Uniform Assessment Tool (pre-assessment) dated February 2, 2026, did not address all required content (some were left blank) such as vital signs, summary of healthcare visits in past 12 months, personal lifestyle preferences, psychotropic/antipsychotic use, depression, neuro-cognitive, mental status, elopement, fall risk, and assistance with activities of daily living. R1's 14-day Monitoring and Reassessment dated February 23, 2026, indicated with checkmarks that R1 was independent with daily dressing, hygiene, and bathing. The assessment indicated R1 was not continent but did not specify if R1 required assistance. Lastly, it included that R1's services were appropriate, service plan was reviewed and did not require any changes. The assessment did not indicate if the assessment was completed face-to-face or via telecommunication.	01620			

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01620	Continued From page 41 R1's 90-day Monitoring and Reassessment dated May 5, 2026, indicated R1 was independent with dressing, hygiene, and bathing. R1 required assistance with laundry and housekeeping. The assessment did not indicate if R1 required assistance with incontinence care, medication administration, or medication administration by staff after setup. The assessment did not indicate if the assessment was completed face-to-face or via telecommunication. During Microsoft Teams video interview on June 10, 2026, at approximately 1:15 p.m., CNS-A stated R1's Uniform Assessment Tool was completed on February 2, 2026, but the entire assessment was not completed because it was "confusing and I did not want to put information in there unless I knew," regarding certain topics, but on some of the topics she did ask about it but it was not documented. CNS-A stated she had intended to go back to the assessment and complete it but forgot to. While completing the 14-day and 90-day assessments, CNS-A's process was to use the one page reassessment form and recall sections of the uniform assessment tool while completing her visit with R1. CNS-A stated she would ask R1 how he was doing, observe him walking, ask about food, looked at R1's cane, and asked staff how R1 was doing. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the ongoing assessments were the foundation for establishing a personalized service plan that addressed resident's needs and preferences. Minnesota Administrative Rule 4659.0150, subpart 1 dated August 11, 2021, indicated the required elements of the uniform assessment tool	01620			

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01620	Continued From page 42 to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650			

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01650	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1) receiving assisted living 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: Between June 8 and 9, 2026, at various times, the surveyor observed staff provide supervision, one-on-one interactions, and assist R1 with transportation set up. R1 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services (DHS) Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. R1's service plan lacked the following required information: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650			

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01650	Continued From page 44 service, according to the resident's current assessment and resident preferences (the support plan was completed through a county assessment, not by licensee); (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On June 8, 2026, at 1:05 p.m., when the surveyor requested R1's service plan, administrator/unlicensed personnel (A/ULP)-C provided R1's DHS Support Plan and stated that was their service plan in use and showed the surveyor the services listed on the support plan. After reviewing service plan content requirements, A/ULP-C stated R1's service plan in use was missing the required content. A/ULP-C provided the surveyor their blank Home Care Service Plan: Part 1 Rate Sheet Agreement which lacked the methods of monitoring staff providing	01650			

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01650	Continued From page 45 services. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following: - a description of the services to be provided; - the fees for services with frequency of each services; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessment of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that includes the following: -action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	01700			

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01700	Continued From page 46 providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) 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	01700			

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01700	Continued From page 47 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: During the entrance conference on June 8, 2026, at 10:26 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to licensee's resident. R1 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. R1's service documentation dated February 1-28, 2026, under Health Related, included staff initials starting February 6, 2026, at 8:00 a.m., indicating "AM [morning] Meds Administered." On February 4-5, 2026, the boxes were solid black for both AM/PM (morning/evening) medications administered. R1's record lacked a Medication Administration Record (MAR) for February and March 2026, to indicate what medications had been administered to R1. PRE-ADMISSION ASSESSMENT R1's Uniform Assessment Tool (pre-admission assessment) dated February 2, 2026, indicated, Under the Review of Medications section,	01700			

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01700	Continued From page 48 included identification of R1's medications, but lacked a review of the side effects, contraindications, allergic or adverse reactions. The assessment also lacked interventions needed in management of medications to prevent diversion. The assessment indicated R1 was able to self-administer two (oral) of the four medications listed. During Microsoft Teams video interview on June 10, 2026, at 12:30 p.m. CNS-A stated R1 administered creams himself and did not have R1 demonstrate his ability to apply the creams, but CNS-A stated she provided R1 education regarding the creams. Regarding identifying R1 could self-administer oral medications, CNS-A stated that was a "mistake." POST-ADMINISTRATION MEDICATION ASSESSMENT R1's Medication Management Assessment dated February 12, 2026, indicated R1 needed assistance with medication setup, medication reminders, medication administration, and medication storage and security. The assessment lacked an assessment of R1's ability to self-administer topical creams. On June 11, 2026, at 11:37 a.m., via email, CNS-A indicated the medication assessment was late because they received prescriber orders on February 11, 2026, then completed the assessment on February 12, 2026. The licensee's Assessment of Medications policy dated August 1, 2021, indicated prior to providing medication management services, [licensee name] would provide an assessment by a registered nurse (RN) to determine what medication management services would be	01700			

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01700	Continued From page 49 provided and how they would be implemented. The assessment would include: -identification of all medications, including over-the-counter and herbal/dietary supplements, -medication reconciliation (identification of the most accurate list of medications the resident is taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider; -assessment of the following: indication of medications, effectiveness of drug therapy, side effects, immediate desired effects, unusual and unexplained effects, actual or potential drug interactions, duplicate drug therapy, non-adherence with drug therapy, drug therapy currently associated with laboratory monitoring, allergic reactions, changes in condition that contraindicate continued administration of medication, and resident preferences in how to take medications; and -interventions needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
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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NAME OF PROVIDER OR SUPPLIER JAYTEE RESIDENTIAL CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5306 HOWE LANE BROOKLYN CENTER, MN 55429			
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01730	Continued From page 50 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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER JAYTEE RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5306 HOWE LANE BROOKLYN CENTER, MN 55429		
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01730	Continued From page 51 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a client'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 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with medication administration and management. R1's After Visit Summary (AVS) dated June 3, 2026, indicated hydrocerin cream, apply generously to back and scalp areas that itch four (4) times per day and urea 40% cream, apply to big toenails every night at bedtime and wrap in some form of dressing or bandage for one week. R1's Medication Administration Record (MAR) dated May 1 through June 30, 2026, indicated R1	01730			

Minnesota Department of Health

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01730	Continued From page 52 received hydrocortisone 1% cream three times daily as needed (PRN) for itchy skin for 14 days; minerin cream (hydrocerin), apply to back and scalp areas that itch four times a day; and urea 40% cream, apply to big toenails at bedtime and wrap in dressing/bandage. R1's Medication Management Assessment dated February 12, 2026, lacked an assessment of R1's ability to self-administer topical creams. On June 9, 2026, at 1:20 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-E demonstrate how he would administer R1's medications. The surveyor observed R1's oral medications. While looking at the paper MAR, the surveyor asked O/ULP-E and administrator/ULP (A/ULP)-C about R1's creams that were listed on the MAR (hydrocortisone, minerin, and urea), O/ULP-E stated R1 self-administered them and R1 kept the creams in his room. O/ULP-E was unable to locate the creams within R1's room and stated R1 may have them on his person. On June 9, 2026, at 2:29 p.m., R1 returned to the facility and was asked if he had the three creams, R1 stated those creams were dispensed by the pharmacy one time but did not refill them since then and did not want them any longer. R1's medication management plan lacked a description of storage of medications based on resident's needs, preferences, risk of diversion, and consistent with manufacturer's directions. On June 11, 2026, at 11:37 a.m., via email, CNS-A indicated an assessment on R1's ability to self-administer topical creams was not completed because it "was an oversight."	01730			

Minnesota Department of Health

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01730	Continued From page 53 The Licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the nurse was responsible for preparing and documenting the medication management plan and the plan would include a description of the storage of medications based on the resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed, document why the medication was not administered as prescribed, and failed to transcribe orders for one of one resident (R1) who received medication	01760			

Minnesota Department of Health

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01760	Continued From page 54 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 8, 2026, at 10:26 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to licensee's resident. R1 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with medication administration and management. R1's prescriber orders dated February 11, 2026, included aspirin 81 mg milligrams (mg) by mouth (po) daily (stroke prevention) and atorvastatin 20 mg po daily (lowered cholesterol). DOCUMENTATION OF MEDICATION ADMINISTRATION R1's service documentation dated February and March 2026, under Health Related, included staff initials starting February 6, 2026, at 8:00 a.m., indicating "AM [morning] Meds Administered."	01760			

Minnesota Department of Health

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01760	Continued From page 55 On February 4-5, 2026, the boxes were solid black for both AM/PM (evening) medications administered (the documentation did not include medication name, dose, route, frequency, purpose, and instructions related to the medication). During observation on June 9, 2026, at 1:20 p.m., the surveyor reviewed R1's medications with owner/ULP (O/ULP)-E and observed the morning bubble pack including aspirin 81 mg tablet and 50 mg tablet. The evening bubble pack included atorvastatin 20 mg tablet. During interview on June 9, 2026, at 2:47 p.m., administrator/unlicensed personnel (A/ULP)-C and O/ULP-E stated the February service documentation was their documentation of providing R1's morning and evening medications because the medication administration record (MAR) did not become available until April 2026. R1's MAR dated May 1 through June 8, 2026, included initials of six (6) staff (DR, SM, MS, TK, LT, and AM). One page of R1's May MAR identified "DR" as ULP-G, and one page of June MAR identified "SM" as A/ULP-C. R1's medical record lacked documentation to include signature and title of four (4) people who administered the medication. DOCUMENTATION OF MEDICATION REFUSALS R1's MAR dated May 1-31, 2026, indicated R1 received medications twice daily in the morning and in the evening. Between May 20-31, 2026, staff wrote "R" 16 times. R1's medical record lacked documentation of reason why R1 refused his medications.	01760			

Minnesota Department of Health

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01760	Continued From page 56 R1's MAR dated June 1-8, 2026, included documentation of "R" 10 times, and the back of the MAR lacked documentation of reason why R1 refused his medication on May 3, 2026, on evening shift and on May 4, 2026, on morning shift. During interview on June 9, 2026, at 1:20 p.m., O/ULP-E stated if R1 refused his medication, he documented the MAR with "R" then wrote the reason why on the back. A/ULP-C stated she circled her initials on the MAR then wrote the reason on the back. TRANSCRIPTION OF ORDERS R1's After Visit Summary (AVS) dated June 3, 2026, ordered lactase 3000 unit tablet, take two (2) tablets by mouth three times daily with meals. The AVS also indicated to discontinue hydrocerin cream and urea 40% cream. R1's MAR dated June 1-30, 2026, indicated the following medications were not discontinued as of June 3, 2026, as ordered: -minerin cream-apply generously to back and scalp areas that itch four times a day (lacked documentation of it being administered); and -urea 40% cream-apply to big toenails at bedtime and wrap in dressing/bandage (lacked documentation of it being administered). During interview on June 9, 2026, at 2:29 p.m., R1 stated his provider had prescribed medication for his stomach irritation recently, "Lactaid?" R1 said he had not received them yet but thought they could be over-the-counter so he would pick some up at the Dollar Tree. R1 stated he no longer used the creams nor wanted them. During Microsoft Teams video interview on June	01760			

Minnesota Department of Health

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01760	Continued From page 57 10, 2026, at 12:30 p.m., CNS-A stated staff were trained to document "R" if R1 refused his medication and write an explanation on the back of the MAR. CNS-A also stated the licensee was waiting for the February and March MAR to arrive from the doctor. When the surveyor asked for documentation showing what medications were administered, CNS-A stated they were "on the computer." CNS-A stated she read group chats among staff but was not aware of R1's recent prescriber order to start Lactase and discontinue two creams. CNS-A stated A/ULP-C would handle the medications, including transcribing orders, and ensuring medications were delivered from the pharmacy. The licensee's Clinical Records policy dated August 1, 2021, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. The clinical record contains documentation of services provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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:	01820			

Minnesota Department of Health

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01820	Continued From page 58 Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained upon admission for one of one resident (R1) receiving 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 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 was admitted to licensee on February 4, 2026, and had diagnoses including type 2 diabetes, history of stroke, and high cholesterol. R1's Minnesota Department of Human Services Support Plan (used as service plan) dated February 4, 2026, through January 31, 2027, indicated R1 required support with homemaking, meals, medication management, medication administration, socialization, and monitoring. On June 9, 2026, at 1:20 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-E demonstrate how he would administer R1's medications. The surveyor observed the following medications for R1: aspirin 81 milligram (mg) tablet (helps prevent stroke), Januvia 50 mg tablet (lowers blood glucose), and atorvastatin 20 mg tablet (lowers cholesterol). R1's record lacked a medication administration record (MAR) for February 2026.	01820			

Minnesota Department of Health

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01820	Continued From page 59 R1's service documentation dated February 1-28, 2026, under Health Related, included staff initials starting February 6, 2026, at 8:00 a.m., indicating "AM Meds Administered." On February 4-5, 2026, the boxes were solid black for both AM/PM (morning/evening) medications administered. R1's prescriber orders dated February 11, 2026, included aspirin 81 mg by mouth (po) daily and atorvastatin 20 mg po daily. During interview on June 9, 2026, at 2:47 p.m., administrator/ULP (A/ULP)-C and O/ULP-E stated the February service documentation was their documentation of providing R1's morning and evening medications because the MAR did not become available until April 2026. R1 lacked prescriber orders for medications administered by licensee for five (5) days. During phone interview on June 10, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated she was shown R1's medications prior to admission, but could not confirm if he came with the same medications upon admission. CNS-A also stated R1 did not have prescriber orders until he went to his appointment on February 11, 2026. CNS-A stated she could not be certain the medications R1 had been taking prior to receiving the orders were correct. During phone interview on June 11, 2026, at 8:45 a.m., the surveyor asked O/ULP-E if R1 had prescriber orders upon admission, O/ULP-E stated he was not sure, but A/ULP-C was waiting for prescriber orders. O/ULP-E stated the first few days after R1's admission, CNS-A was out of town, so she was not available.	01820			

Minnesota Department of Health

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01820	Continued From page 60 The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber and to identify any expired or outdated medications, which would be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Jaytee Residential Care LLC
5306 Howe Lane
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:
jayteeresidentialcare@gmail.com

License Info

License: HFID 42815

Risk:
License:
Expires on:
CFPM: Yarleh Weah
CFPM #: 55680; Exp: 01/25/2028

Inspection Info

Report Number: F8044261176
Inspection Type: Full - Single
Date: 6/9/2026 Time: 10:20:54 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

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

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

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

COMMENT: No procedures in place.

Poster provided with report.

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

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: No irreversible thermometer or test strips/stickers for dishwasher.

Comply By: 6/15/2026 Originally Issued On: 6/9/2026

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 *Priority Level: Priority 1 CFP#: 28*

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: Clorox wipes and cleaner used on food contact surfaces is not approved for this use.

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

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Anna Bohnen. Inspection report reviewed on site with Sweetee Miller.

Domestic kitchen consists of tile floors, wooden hollow-base cabinets, laminate counters, tile backsplash, painted gypsum walls and ceiling, and domestic equipment.

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 Rochester District Office inspection report number F8044261176 from 6/9/2026



Sweetee Miller
Admin

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

Jaytee Residential Care LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261176
Inspection Type: Full
Date: 6/9/2026
Time: 10:20:54 AM

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

Location: Refrigerator at 40.4 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator at 39.0 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL42815015-0	Date: 6/9/2026
Facility Name: JAYTEE RESIDENTIAL CARE LLC	
Facility Address: 5306 HOWE LANE BROOKLYN CENTER, MN	

☒ TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) 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 tile in the lower-level shower was unsecured and missing in spots.
- Old appliances were observed being stored in the rear yard.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]
- Comments: The resident rooms identification did not match the posted evacuation floor plans identification
2. 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 FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

3. 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 FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The licensee stated a resident policy was not in place at the time of the survey.