



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

May 11, 2025

Licensee

unity homes INC

767 7th Avenue Northwest

New Brighton, MN 55112

RE: Denial of License Number 414774
Health Facility Identification Number (HFID) 40129
Initial survey; Project Number(s) SL40129015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on March 21, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **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>

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jess Schoenecker, via email at: Jess.Schoenecker@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **May 15, 2025**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Jess Schoenecker, Supervisor, at Jess.Schoenecker@state.mn.us. Jess Schoenecker can also be reached by office phone at 651-201-3789.

Sincerely,

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

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: 40129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER UNITY HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 767 7TH AVENUE NORTHWEST NEW BRIGHTON, MN 55112			
(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 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: SL40129015-0 On March 17, 2025, through March 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one (1) resident, one resident whom received services under the provisional Assisted Living Facility license. On March 20, 2025, 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.		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (the Department) with accurate and truthful information on staff training, R1's nursing assessments, quality management meetings, staff availability, and staff schedule/timesheets during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On March 17, 2025, at 9:53 a.m., the surveyor contacted registered nurse (RN)-J (was listed as the clinical nurse supervisor (CNS) on licensee's provisional license application) by phone and RN-J stated she was not employed by the licensee.	0 330			

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0 330	Continued From page 2 EMPLOYEE RECORDS The licensee's updated employee roster indicated the following hire dates: - unlicensed personnel/house manager (ULP/HM)-B-September 27, 2024; -CNS-A-January 1, 2025; -unlicensed personnel/administrator (ULP/A)-C-September 30, 2024; -ULP-D-September 27, 2024; and -ULP-E-September 30, 2024. During employee record review between March 18, 2025, through March 21, 2025, the surveyor had observed the following documents containing the first and last name and/or signature of RN-J: -ULP/HM-B's Practical Skills/nursing delegated competencies including oral medication administration, topical medication training, 30-day supervision, dementia quiz, orientation check list, and TB (tuberculosis) Tool for Health Care Workers form; -ULP/A-C's-orientation check list, oral medication administration competency, and practical skills competency; -ULP-D's-practical skills competency, oral medication administration competency, and orientation checklist; and -ULP-E's-orientation check list. Throughout the employee records, the surveyor observed RN-J's signature to vary from document to document. On March 21, 2025, at 10:34 a.m., RN-J provided the surveyor a picture of her printed full name printed and signature via text message. The name and signature did not resemble the signatures used on staff training. RESIDENT RECORD	0 330			

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0 330	Continued From page 3 R1 was admitted to licensee for services on October 1, 2024. R1's medical record included the following documents with RN-J's electronically signed signature on licensee's electronic health record program (RTasks): -initial admission assessment dated October 1, 2024, at 9:32 a.m., e-signed by RN-J; and -14-day nursing assessment dated October 14, 2024, at 12:01 p.m., e-signed by RN-J. During interview on March 18, 2025, at 11:24 a.m., R1 stated he signed paperwork upon admission, but did not remember going through the paperwork. He also could not remember if he was assessed by an RN. FACILITY RECORD Licensee's Quality Management Agenda dated October 12, 2024, and December 14, 2024, indicated RN-J attended the meetings by listing RN-J's first and last name under "Attendance." During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a one-time fee. She explained she never admitted any residents for the licensee, never been on their electronic health record (Rtask) which she was not familiar with, and never met ULP/HM-B, ULP/A-C, or ULP-D. She was shocked to find out her name was being documented on resident and employee records and was worried what happen. On March 20, 2025, at 12:30 p.m., the surveyor received a text message from licensed assisted living director (LALD)-F that read RN-J and RN-G were former RNs and that RN-J did all employee	0 330			

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0 330	Continued From page 4 training. On March 21, 2025, at 9:08 a.m., an email was sent asking when RN-J's last day of employment was and never received a response by the end of the survey. During phone interview on March 21, 2025, at 10:38 a.m., RN-J again explained she assisted O/A-K with the provisional assisted living licensure application. She assisted with the paperwork, went through the facility inspection with the inspector, and a few times provided contact information to O/A-K when requested. RN-J also explained she was paid a one-time fee in 2023, but was never hired to be the facility nurse, had never met R1, nor met any of the staff. RN-J also explained she never completed any nursing assessments nor completed any staff training because she was never employed to complete those tasks. During phone interview on March 21, 2025, at 1:05 p.m., the surveyor asked ULP/A-C who trained her, she stated, "I think it was the old nurse [RN-J's name]," and met her once or twice because RN-J was the nurse for the first few weeks. The surveyor showed her on Microsoft Teams application (viewed presenters documents) ULP/HM-B's practical skills competency dated September 30, 2024, and asked if the evaluator's initials and signatures was RN-J's and she stated yes. The surveyor then compared signatures from the practical skills competency to the oral medication competency dated October 1, 2024, and asked if the signatures were different, she stated "I guess." The surveyor asked why the signatures were different, she stated all she did was pull the documents out of the file and sent it to the	0 330			

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0 330	Continued From page 5 surveyor and that she had met someone by the name of [RN-J's name] and said, "that's all I know, you would need to talk to the owner." At 2:13 p.m., by text message, LALD-F indicated he had never met RN-J, but knew she was the former RN. The surveyor asked if RN-J had worked from September 1, 2024, and beyond, and LALD-F did not know, had never met RN-J and to direct that question to the owner. LALD-F indicated he was not responsible for hiring but was responsible for the day-to-day operation and overseeing staff once hired. DIRECTOR AVAILABILITY During entrance conference on March 17, 2025, at 11:15 a.m., ULP/HM-B stated LALD-F was the licensee's director. On March 17, 2025, at 11:57 a.m., via email, the surveyor received the licensee's undated employee list which did not show LALD-F listed as a current employee. The surveyor requested an updated list to include LALD-F. On March 17, 2025, at 1:02 p.m., during required posting review, the surveyor observed LALD-F's weekly location schedule which indicated LALD-F was LALD for a total of five (5) facilities and was scheduled to be at this facility every Friday, and was available by phone on Tuesdays, Wednesdays, Thursdays, Saturdays, and Sundays. The phone number listed for LALD-F was the phone number for CNS-A. On March 19, 2025, at 12:13 p.m., via email, the surveyor received an updated employee list to include LALD-F with hire date and different phone number than what was listed on the LALD-F weekly location schedule.	0 330			

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0 330	Continued From page 6 On March 17-19, 2025, the surveyor was on-site conducting observations, interviews and record reviews. The surveyor did not see or hear from LALD-F as ULP/HM-B and ULP/A-C were the contact people for requests or questions. On March 20, 2025, at 10:32 a.m., the surveyor called LALD-F for questions, but the call went right to voicemail (VM) and the voicemail box was full so a message could not be left. At 11:39 a.m., the surveyor called LALD-F, call went right to VM. At 12:15 p.m., LALD-F called the surveyor and explained he began employment on September 6, 2024, and his role included supervising residents/staff, record audits, and checked with nursing staff to make sure return demonstrations were completed. The surveyor asked if he had concerns with documentation compliance, he stated not that he could recall. The phone cut out, so text messages were sent for further questions. At 12:30 p.m., the surveyor received a text message from LALD-F that read RN-J and RN-G were former RNs and that RN-J completed employee training. During phone interview on March 21, 2025, at 1:05 p.m., ULP/A-C stated LALD-F was on site once or twice a week and was available 24 hours a day, 7 days a week. The surveyor asked why LALD-F had not been involved in this survey, she responded "I do not know, I only call when I need him." ULP/A-C stated she informed LALD-F on Monday there was a survey and LALD-F stated to her he was available by phone if needed.	0 330			

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0 330	Continued From page 7 At 1:45 p.m., during phone interview, LALD-F stated he worked 2-3 days per week and was at the facility last week. He was available by phone 24/7 for any questions. LALD-F stated he was not aware there was a survey until ULP-D told him on Tuesday. DOCUMENTATION DISCREPANCIES During entrance conference on March 17, 2025, at 11:15 a.m., ULP/HM-B stated one ULP worked each shift, and each shift was 7:00 a.m.-3:00 p.m., 3:00 p.m.-11:00 p.m., and 11:00 p.m.-7:00 a.m. The licensee's March 2025 staff work schedule dated March 2, through April 2, 2025, indicated the following: -ULP/HM-B was scheduled Monday through Friday from 7:00 a.m.-3:00 p.m.; -ULP-D was scheduled Monday through Friday from 3:00 p.m.-11:00 p.m.; -ULP/A-C was scheduled Monday through Friday from 11:00 p.m.-7:00 a.m.; and -ULP-E was scheduled Saturday and Sundays from 7:00 a.m.-7:00 p.m. R1's March Medication Administration Record (MAR) dated March 1 through 7, 2025, included the following written documentation discrepancies: -March 1 at 8:00 a.m., documented with ULP-D's initials indicating three medications were administered, ULP-D did not work this day per timesheet; and -March 3-7 at 8:00 p.m., documented with ULP/A-C's initials indicating three medications were administered, ULP/A-C worked 11:00 p.m.-7:00 a.m. per timesheet. ULP/HM-B's timesheet dated March 3-7, 2025,	0 330			

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0 330	Continued From page 8 read ULP/HM-B worked 3:00 p.m.-11:00 p.m. R1's MAR showed ULP/A-C documented medication administration during ULP/HM-B's schedule. R1's March electronic MAR dated March 7 through 16, 2025, read ULP/A-C's initials every day at 8:00 a.m. and 8:00 p.m., ULP-D's timesheet indicated AM shift on March 7, and PM shift from March 10 through 14, 2025. ULP/A-C's timesheet indicated she worked overnight shift (11:00 p.m. to 7 a.m.) from March 9, through March 15, 2025. On March 19, 2025, at 11:15 a.m., ULP/HM-B stated she worked Monday through Friday of each week from 7:00 a.m. to 3:00 p.m. When asked why her name was not documented on the MAR, she stated she did not realize she was documenting under someone else's name until yesterday which she logged out and logged in as herself. During phone interview on March 21, 2025, at 1:05 p.m., ULP/A-C was asked about the timesheet/MAR discrepancy, and asked why the timesheet read she worked overnights, but her initials were on R1's 8:00 p.m. medications, she stated R1 sometimes took his medications late and she should have changed the time on the MAR. It was asked why the evening staff did not administer or document the refusal; she could not explain why it was charted by her. ULP/A-C explained she saved her password on Rtask when she logged in, and people did not know they were charting under her name but said it was on her. When asked about the paper MAR indicating she charted on R1's 8:00 p.m. medications when the timesheet indicated she worked overnight shift, she could not explain the	0 330			

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0 330	Continued From page 9 reason why. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. 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:	0 420			

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0 420	Continued From page 10 During the survey from March 17, 2025, through March 21, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents. The licensee had a provisional assisted living license, effective December 26, 2023. The licensee's "Provisional Assisted Living Licensure Information and Application", section titled "Official Verification of Owner or Authorized Agent", (page 17 and 18 of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page 18 was electronically signed by the owner/agent (O/A)-K on October 21, 2022. As a result of this survey, the following orders were issued under 0330, 0420, 0480, 0495, 0550,	0 420			

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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
0 420	Continued From page 11 0570, 0650, 0660, 0680, 0690, 0730, 0775, 0780, 0800, 0810, 0940, 1370, 1380, 1440, 1460, 1560, 1610, 1620, 1730, 1750, 1760, 1790, 1820, 1880, and 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of	0 480			

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0 480	Continued From page 12 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 480			

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0 480	Continued From page 13 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 March 17, 2025, 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 provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	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 14 The findings include: R1's diagnoses included schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received services including assistance with appointment reminder/assistance, bedmaking, deep room cleaning, housing keeping, laundry, behavior management, meals, medication administration, garbage removal, and shopping assistance. During entrance conference on March 17, 2025, at 11:15 a.m., unlicensed personnel/house manager (ULP/HM)-B stated clinical nurse supervisor (CNS)-A worked at the facility two days a week, eight or nine hour days, on the days she did not work at the hospital. ULP/HM-B stated former registered nurse (RN)-G was back up on-call if CNS-A was unavailable due to working overnights at the hospital. She also stated RN-G was only on-call, and did not perform nursing duties at the facility. ULP/HM-B stated one unlicensed personnel (ULP) worked alone on each shift. On March 17, 2025, at 11:26 a.m., the surveyor received the employee list that indicated RN-G was a current employee and was hired as an RN on November 22, 2024. During facility tour on March 17, 2025, at 12:30 p.m., the surveyor observed the daily staff schedule posted on the wall indicating "*24 hour	0 495			

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0 495	Continued From page 15 on call [name of CNS-A and phone number]." On March 18, 2025, at 8:41 a.m., ULP/HM-B showed the surveyor R1's medications and explained how she would administer medications by comparing the information on the bubble pack to the information on R1's electronic health record (RTask). On March 18, 2025, at 11:38 a.m., CNS-A arrived at the facility and stated she worked at the Fairview Hospital system along with the licensee. On March 19, 2025, at 12:13 p.m., an updated current employee list was received by email which did not include RN-G as a current employee. During phone interview on March 20, 2025, at 10:34 a.m., CNS-A stated currently she did not have an on-call rotation with any other nursing staff. She assumed RN-G was back up but didn't know for how long as the licensee was in the process of hiring another nurse. CNS-A explained she worked overnights at her hospital job and would not be available to answer calls during her shift. She said she had not received any calls yet but did receive calls early morning or throughout the day when she was available. On March 20, 2025, at 12:15 p.m., and 12:39 p.m., emails received indicated RN-G no longer worked for the licensee as of January 13, 2025. The licensee's Staffing Plan dated November 1, 2024, indicated there was one care staff per shift, and the RN was available 24 hours a day on call. It also stated the assisted living director was available as a backup if the RN was unavailable to consult right away.	0 495			

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0 495	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current resident, 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	0 550			

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0 550	Continued From page 17 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: During observation on March 17, 2025, at 1:10 p.m., the surveyor asked unlicensed personnel/house manager (ULP/HM)-B where the grievance procedure was posted, and upon looking all over, she was unable to locate it. ULP/HM-B stated ULP/administrator (ULP/A)-C was responsible for all postings. On March 17, 2025, at 3:13 p.m., ULP-D provided the surveyor their grievance procedure which was in a white binder inside of a plastic drawer unit within the living room. The licensee's undated 2.10 Complaint/Grievance Posting policy, indicated the licensee would post, in a conspicuous place, information about their complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility.	0 570			

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0 570	Continued From page 18 The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility. This had the potential to affect all 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: On March 17, 2025, at 1:05 p.m., the surveyor observed a copy of the licensee's provisional license on an 8.5" by 11" printer paper with effective date December 26, 2023, and expiration date December 25, 2024, posted on the wall between the living room and kitchen. On March 17, 2025, at 2:18 p.m., during phone interview, unlicensed personnel/administrator (ULP/A)-C stated she was in charge of the postings but was not sure why the original license was not posted and would need to ask the owner. The licensee's undated 2.04 Assisted Living License and Posting policy, indicated the original current license shall be displayed at the main entrance. A copy of the assisted living license would be provided to any person who requested	0 570			

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0 570	Continued From page 19 it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 650 SS=E	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	0 650			

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0 650	Continued From page 20 two employees (unlicensed personnel/house manager (ULP/HM)-B, 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 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: ULP/HM-B ULP/HM-B was hired on September 27, 2024, to provide direct care and services to the facility's residents. From March 17, 2025, through March 19, 2025, the surveyor observed ULP/HM-B work each day the surveyor was there providing supervision within the facility and while on outings with R1, assist with coordinating medical appointments for R1, and complete housekeeping tasks. ULP/HM-B's online training transcript dated September 25-30, 2024, indicated ULP/HM-B completed training on the following orientation topics: overview of assisted living statutes, assisted living bill of rights, handling of emergencies and using emergency services, reporting maltreatment of vulnerable adults or minors, handling of resident complaints, consumer advocacy services, review of types of assisted living services the employee will provide, person-centered planning, and dementia training.	0 650			

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0 650	Continued From page 21 ULP/HM-B's [name of a different licensee] Orientation Checklist dated September 27, 2024, indicated registered nurse (RN)-J signed that ULP/HM-B completed training on personnel policies. The orientation checklist was not signed by ULP/HM-B attesting training was received. CNS-A CNS-A was hired on January 27, 2025, to provide direct care and services to the facility's residents and training to licensee's staff. During observation on March 18, 2025, between 11:38 a.m. and 3:00 p.m., CNS-A assisted the surveyor with questions and R1 with coordinating appointments and provided reassurance when he became anxious. CNS-A's record lacked documentation of the following: - review of provider's policies and procedures. During interview on March 17, 2025, at 4:12 p.m., CNS-A stated she was trained on the licensee's policies and procedures. The licensee's undated 4.18 Employee General Orientation policy, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer would be oriented in accordance with state and federal regulations, as well as company policy and procedure. An orientation checklist would be completed by the employee and trainer, signed by each person, and would be filed in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			

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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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel/house manager (ULP/HM)-B). 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	0 660			

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0 660	Continued From page 23 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment completed by licensed assisted living director (LALD)-F on December 11, 2024, indicated the licensee's TB risk level was low. The Assessment also indicated a response of "yes" when asked if a baseline TB screening of all health care personnel was performed at time of hire. ULP/HM-B was hired on September 27, 2024, to provide direct care and managerial duties. From March 17, 2025, through March 19, 2025, the surveyor observed ULP/HM-B work each day by providing supervision within the facility, took R1 on an outing, assist with coordinating medical appointments, and complete housekeeping tasks. ULP/HM-B's Baseline TB Screening Tool for Healthcare Workers form dated September 27, 2024, assessed the history and assessing for current symptoms of active TB disease. During interview on March 18, 2025, at 9:20 a.m., ULP/HM-B explained she began working for licensee about a year ago to help prepare the facility for their provisional assisted living licensure. On March 19, 2025, at 10:44 a.m., via text message, ULP/HM-B provided a photo of her negative one-step TST completed on July 26, 2023. During interview, ULP/HM-B stated she did not complete the second TST as it was serial test which she thought had to be completed every two years. She stated this test was completed	0 660			

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0 660	Continued From page 24 through her other job, and did not complete any TB testing for this licensee. During interview at 12:13 p.m., the surveyor asked if all staff had received TB screening upon hire, ULP/administrator (ULP/A)-C stated she wasn't sure and would check for records. The surveyor then asked ULP/A-C if she received TB screening upon hire, she stated she did not. The licensee's March 2025 staff schedule indicated ULP/HM-B was scheduled to work Monday through Friday from 7:00 a.m. to 3:00 p.m., and ULP/A-C was scheduled Monday through Friday from 11:00 p.m. to 7:00 a.m. The licensee's undated Exposure Control Plan, indicated new staff shall be screened for active signs of TB using the Baseline TB Screening Tool, new staff shall have a two-step TST with results documented on the Baseline TB Screening Tool or an approved blood test, and no staff shall be permitted to begin work where the work involves sharing the air space with home care clients until the TB screen is negative and the results of the 1st step TST are negative or an approved blood test result is negative and documented. The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated December 13, 2024, indicated a baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of Mycobacterium tuberculosis by administering either a two-step	0 660			

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0 660	Continued From page 25 TST or single TB blood test. 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 680			

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0 680	Continued From page 26 review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. The licensee also failed to post emergency exit diagrams on each floor. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 17, 2025, at 12:30 p.m., during facility tour with unlicensed personnel/house manager (ULP/HM)-B, the surveyor observed a split-level home. Upon entry of the home, there was an entry way with closet. There were steps to go upstairs or downstairs. The upper level had three bedrooms (one of them occupied), and the lower level had two unoccupied bedrooms. The surveyor did not observe an emergency exit diagram posted on the upper level nor the lower level. During phone interview on March 17, 2025, at 2:18 p.m., unlicensed personnel/administrator (ULP/A)-C stated she was in charge of revamping the postings and while she was at the facility, she noticed some things were not posted that needed to be put back up. During EPP review on March 17, 2025, at 2:45 p.m., the surveyor asked ULP/HM-B if there were	0 680			

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0 680	Continued From page 27 any additional records available such as the hazard vulnerability assessment (HVA), contact list, etc. She stated ULP/A-C had handled/created the EPP and there may be additional information in the fire drill binder but otherwise, nothing more that she knew of. The fire drill binder was provided to the surveyor to review. The licensee's emergency disaster preparedness plan created October 15, 2024, lacked evidence of the following required content: - the development of policies/procedures to address: -subsistence needs for staff and residents specific to the needs of the facility; -tracking of staff and patients; -medical documents; -use of volunteers; and -sharing information on occupancy/needs. On March 18, 2025, at 10:45 a.m., during EPP discussion with ULP/HM-B, the surveyor observed the following documents were added since the day prior (HVA, documentation of EPP review, communication plan-contact information, and agreement with another facility for emergency placement). The surveyor requested the policy and procedure for tracking staff and residents and use of volunteers. ULP/HM-B was unable to locate the information. ULP/HM-B explained during a power outage, they would contact the power company for estimated time to restore power, she said if it was more than an hour in the wintertime, they would relocate. The surveyor explained specific information such as that could be added to the EPP to tailor the plan to the facility. ULP/HM-B understood what information was missing and was directed to the Minnesota Department of Health website for further information.	0 680			

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0 680	Continued From page 28 The licensee's undated 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy, indicated the licensee's EPP would include policies and procedures designed to align with the requirements in Appendix Z. The licensee's undated 9.02 Disaster Planning and Emergency Preparedness policy, indicated the licensee would post emergency exit diagrams on each floor of the facility. 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 resident records were permanently recorded, current, and 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 was issued at a widespread scope (when	0 690			

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0 690	Continued From page 29 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 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received services including assistance with appointment reminder/assistance, bedmaking, deep room cleaning, housing keeping, laundry, behavior management, meals, medication administration, garbage removal, and shopping. R1's Service Recap Summary dated February 20, through February 28, 2025, and March 7, through 16, 2025, included documentation of services by unlicensed personnel/administrator (ULP/A)-C for all the following times: morning (AM), 8:00 a.m., 12:00 p.m., midday, afternoon/evening (PM), 6:00 p.m., and overnight. The licensee's March 2025 staff work schedule dated March 2, through April 2, 2025, indicated the following: -unlicensed personnel/house manager (ULP/HM)-B was scheduled Monday through Friday from 7:00 a.m.-3:00 p.m.; -ULP-D was scheduled Monday through Friday from 3:00 p.m.-11:00 p.m.; -ULP/A-C was scheduled Monday through Friday from 11:00 p.m.-7:00 a.m.; and -ULP-E was scheduled Saturday and Sundays	0 690			

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0 690	Continued From page 30 from 7:00 a.m.-7:00 p.m. During interview on March 19, 2025, at 11:15 a.m., ULP/HM-B stated she worked Monday through Friday from 7:00 a.m. to 3:00 p.m. The surveyor asked why R1's service recap did not show her documentation of services provided to R1. She explained she did not realize she was documenting under someone else on the licensee's electronic health record (RTasks) and realized the mistake the day prior and began logging in as herself. For the month of February, she took a leave of absence for personal reasons and was not working. The licensee's undated 2.37 Resident Record-Documentation policy, indicated all documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;	0 730			

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0 730	Continued From page 31 (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730			

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0 730	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided 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: R1 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received services including assistance with appointment reminder/assistance, bedmaking, deep room cleaning, housing keeping, laundry, behavior management, meals, medication administration, garbage removal, and shopping. R1's record lacked documentation the following services were provided by the licensee as identified in the service plan: -behavior management (agitation, anxiety, repetitive, self-injurious, verbal, paranoia) on AM (day), PM (evening), and overnight shifts on March 1-6, 9, 11 (overnight only):	0 730			

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0 730	Continued From page 33 -bedmaking, garbage removal, and housekeeping daily on AM and midday shifts (March 1-6); -deep room clean on AM shift on March 5; and -meal assistance at noon, and PM shift on March 1-6. During interview on March 19, 2025, at 11:15 a.m., unlicensed personnel/house manager (ULP/HM)-B explained the licensee was having issues with the electronic health record (RTasks) or the internet so they used a paper charting form, but it was not available on site for the surveyor to review as it was given to the office. During interview at 12:13 p.m., unlicensed personnel/administrator (ULP/A)-C stated Rtasks was unavailable due to lack of payment from March 1-6, 2025. ULP/A-C stated licensee lacked documentation of services provided. Licensed assisted living director (LALD)-F and clinical nurse supervisor (CNS)-A were responsible for checking documentation compliance. During phone interview on March 20, 2025, at 12:15 p.m., LALD-F explained his role included supervising residents, speaking with family members, and ensuring staff were performing the job. LALD-F stated he completed record audits on new hires. LALD-F stated he did not have any concerns with documentation. The licensee's undated 2.37 Resident Record - Documentation policy, indicated staff authorized to document in a resident record will do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. No further information was provided.	0 730			

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0 730	Continued From page 34	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide appropriate disposal areas for smoking materials in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect 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) 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: On March 18, 2025, from approximately 11:08 a.m. to 11:59 a.m., the surveyor toured the facility with unlicensed personnel/ house manager (ULP/HM)-B and observed the following deficient conditions: Multiple cigarettes were present on the ground and porch of the facility. Cigarettes should be	0 775			

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0 775	Continued From page 35 disposed of properly in approved containers. The improper disposal of smoking materials such as cigarettes poses risk of fire. The surveyor explained requirements and noted deficient conditions in the facility, as well as the importance of maintaining proper disposal of smoking materials. ULP/HM-B stated that they understood the requirements and were unsure of the source of cigarettes as reportedly no current residents regularly smoke cigarettes. ULP/HM-B stated smoking materials would be cleaned and they would ensure future smoking materials are properly disposed of. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780			

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0 780	Continued From page 36 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This had the potential to directly 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During a facility tour on March 18, 2025, from 11:08 a.m. through 11:59 a.m. with unlicensed personnel/house manager (ULP/HM)-B, the surveyor observed the following deficient conditions: Smoke alarms were not fully interconnected such that activation of any alarm would cause all alarms to sound throughout the facility. ULP/HM-B tested smoke alarm in resident room 1 and the smoke alarms provided in the hallways were not activated. ULP/HM-B tested smoke	0 780			

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0 780	Continued From page 37 alarm in upper hallway and both hallway alarms were activated. Smoke alarms should be configured such that all alarms provided, in both hallways and resident rooms, should be activated when any alarm is sounded. Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms. All smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. During the tour ULP/HM-B tested the smoke alarms and verified the smoke alarms in the bedroom hallways were not interconnected with other smoke alarms in resident rooms throughout the facility. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation	0 800			

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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
0 800	Continued From page 38 with regard to the health, safety, and well-being of the residents. This had the potential to directly 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 18, 2025, from approximately 11:08 a.m. to 11:59 a.m., the surveyor toured the facility with unlicensed personnel/house manager (ULP/HM)-B. During the tour the surveyor observed the following. The countertop around the sink in the basement bathroom was significantly cracked and damaged. An outlet in the basement hallway was missing an outlet cover. Electrical fixture should be equipped with an electrical cover to prevent contact with electrical fixture. A closet door in the basement hallway was damaged with a significant damage present. The ventilation fan was not operable when activated in the basement bathroom. The surveyor and ULP/HM-B attempted to turn the fan on but found it to not be functional. The ventilation fan in the upstairs bathroom	0 800			

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0 800	Continued From page 39 produced a loud grinding noise and was visibly dirty when activated. Fan should be cleaned and maintained in proper working order. Water damage was present to ceiling and flooring in basement bedroom with warped and caved in ceiling tiles and damaged flooring. During the facility tour interview on March 18, 2025, ULP/HM-B verified the above listed physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810			

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0 810	Continued From page 40 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, at approximately 11:40 a.m., unlicensed personnel/house manager (ULP/HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility	0 810			

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0 810	Continued From page 41 The licensee FSEP failed to include the following: The FSEP did not include any employee actions to be taken in event of fire or similar emergency. Provided documents in the FSEP indicated the rear door as a marked egress route but did not address that both side gates leading from rear yard to right of way were locked shut, and rear gate of yard leading to railroad tracks was significantly overgrown and not readily usable. FSEP did not address evacuation plan or considerations on how to evacuate staff or residents from rear yard. ULP/HM-B stated they were not certain of policies addressing locked gates or evacuation measures. The FSEP did not include fire procedures for residents. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year. The FSEP did not include documentation of training for staff on the FSEP. Employees should receive training on the FSEP upon hire and at least twice a year thereafter. During the record review and interview on March 18, 2025, ULP/HM-B verified the above listed documents were absent from the FSEP. ULP/HM-B stated that they understood requirements and would develop resident fire procedures for residents and staff, and implement and record trainings with residents and staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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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: (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	0 940			

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0 940	Continued From page 43 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received services including assistance with appointment reminder/assistance, bedmaking, deep room cleaning, housing keeping, laundry, behavior management, meals, medication administration, garbage removal, and shopping. R1's [Licensee] Resident Contract for Assisted Living signed October 1, 2024, lacked 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 was enrolled with the commissioner of human services to provide customized living services under medical	0 940			

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0 940	Continued From page 44 assistance waivers; - whether the facility had an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); and -a description of the rent requirements for people who were eligible for medical assistance waivers but who were not eligible for assistance through the housing support program. On March 19, 2025, at 9:31 a.m., upon review of the missing contract content with unlicensed personnel/administrator (ULP/A)-C, ULP/A-C was not aware of the content requirement and would contact their consultant for further details. R1's contract was their current contract used for all residents. The licensee's undated 1.05 Signing an Assisted Living Contract policy, indicated when a prospective resident decides to move into [licensee] a signed assisted living contract signed and received by the facility. The policy also indicated the licensee to review the assisted living contract with the prospective resident and/or responsible person and answer any questions they may have. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided;	01370			

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01370	Continued From page 45 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all	01370			

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01370	Continued From page 46 required skill areas, prior to providing services, for four of four employees (unlicensed personnel/house manager (ULP/HM)-B, unlicensed personnel/administrator (ULP/A)-C, ULP-D, ULP-E). 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: ULP/HM-B was hired by the licensee on September 27, 2024, to provide assisted living services and managerial duties. ULP/A-C was hired on September 30, 2024, to provide assisted living services and administrative duties. ULP-D and ULP-E were hired on September 27, 2024, and September 30, 2024, respectively, to provide assisted living services. During entrance conference on March 17, 2025, at 11:15 a.m., ULP/HM-B stated newly employed staff were trained on medication administration, full body lifts (Hoyer), wheelchair use, sit to stand lift, and how to complete exercises by the nurse. ULP/HM-B, ULP/A-C, and ULP-E's Home Health Aide Competency Evaluation dated September 30, 2024, and ULP-D's dated September 27, 2024, respectively, included registered nurse's (RN-J) initials next to bathing, hair	01370			

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01370	Continued From page 47 care/shampoo/shaving, oral hygiene: teeth, gums and oral prosthetics, dressing, toileting, stand-by assist, and care and use of hearing aids. These documents were signed by RN-J indicating ULP/HM-B, ULP/A-C, ULP-D, and ULP-E were competent to perform the above tasks. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a fee to assist. She was not familiar with, and had never met ULP/HM-B, ULP/A-C, or ULP-D. She was shocked to find out her name was used to document on employee records. On March 21, 2025, at 10:34 a.m., RN-J provided the surveyor a photo of her written name and signature which did not match the signatures on the above training records. ULP/HM-B, ULP/A-C, ULP-D, and ULP-E's training record lacked the following required competency testing conducted by a valid registered nurse: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. From March 17, 2025, through March 19, 2025, the surveyor observed ULP/HM-B providing supervision, transportation, and assistance with medical appointments to R1.	01370			

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01370	Continued From page 48 On March 17, 2025, at 12:39 a.m., R1 and ULP/A-C returned from R1's medical appointment. At 3:06 p.m., ULP-D arrived at facility to begin the evening shift. During phone interview on March 20, 2025, at 12:15 p.m., licensed assisted living director (LALD)-F stated his role included supervising residents, speaking with family members and check with nursing staff to make sure return demonstrations were done. The surveyor asked who the nursing staff were, then the phone cut out. On March 20, 2025, at 12:30 p.m., by text message from LALD-F, he indicated RN-J and RN-G were former nurses and RN-J completed the employee training. During phone interview on March 21, 2025, at 1:05 p.m., ULP/A-C was asked who trained her, she stated "I think it was the old nurse [RN-J]" whom trained her on orientation, skills, and medication administration. She said she met RN-J once or twice and that RN-J was the nurse for a few weeks but was unable to provide the surveyor an approximate resignation date. ULP/A-C stated RN-G did a refresher training when she began working late October but was not sure if that refresher training was documented. The surveyor attempted to contact RN-G to verify training, but did not receive a return call by the end of the survey. The licensee's undated 4.05 Employee Records policy, indicated records of all training and in-service education required and/or provided including record of competency testing as	01370			

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01370	Continued From page 49 required. The policy also indicated licensee would verify completed orientation, annual training, and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for four of four employees (unlicensed personnel/house manager (ULP/HM)-B, unlicensed personnel/administrator (ULP/A)-C,	01380			

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01380	Continued From page 50 ULP-D, ULP-E). 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: ULP/HM-B was hired by the licensee on September 27, 2024, to provide assisted living services and managerial duties. ULP/A-C was hired on September 30, 2024, to provide assisted living services and administrative duties. ULP-D and ULP-E were hired on September 27, 2024, and September 30, 2024, respectively, to provide assisted living services. During entrance conference on March 17, 2025, at 11:15 a.m., ULP/HM-B stated newly employed staff were trained on medication administration, full body lifts (Hoyer), wheelchair use, sit to stand lift, and how to complete exercises by the nurse. ULP/HM-B, ULP/A-C, ULP-D, and ULP-E's Home Health Aide Competency Evaluation dated September 30, 2024 (ULP/HM-B, ULP/A-C, and ULP-E), and September 27, 2024 (ULP-D), respectively, included registered nurse's (RN-J) initials next to temperature, pulse, respiration, safe transfer techniques/ambulation, positioning (on side and chair), and range of motioning. This document was signed by RN-J indicating	01380			

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01380	Continued From page 51 ULP/HM-B, ULP/A-C, ULP-D, and ULP-E were competent to perform the above tasks. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a fee to assist. She was not familiar with, and had never met ULP/HM-B, ULP/A-C, or ULP-D. She was shocked to find out her name was used to document on employee records. On March 21, 2025, at 10:34 a.m., RN-J provided the surveyor a photo of her written name and signature which did not match the signatures on the above training records. ULP/HM-B, ULP/A-C, ULP-D, and ULP-E's training record lacked the following required competency testing conducted by a valid registered nurse: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. From March 17, 2025, through March 19, 2025, the surveyor observed ULP/HM-B workday shift providing supervision, transportation, and assistance with medical appointments to R1. On March 17, 2025, at 12:39 a.m., R1 and ULP/A-C returned from R1's medical appointment. At 3:06 p.m., ULP-D arrived at facility to begin the evening shift. During phone interview on March 20, 2025, at 12:15 p.m., licensed assisted living director (LALD)-F stated his role included supervising residents, speaking with family members and	01380			

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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
01380	Continued From page 52 check with nursing staff to make sure return demonstrations were done. The surveyor asked who the nursing staff were, then the phone cut out. At 12:30 p.m., by text message from LALD-F, he indicated RN-J and RN-G were former nurses and RN-J completed the employee training. During phone interview on March 21, 2025, at 1:05 p.m., ULP/A-C was asked who trained her, she stated "I think it was the old nurse [RN-J]" who trained her on orientation, skills, and medication administration. She said she met RN-J once or twice and that RN-J was the nurse for a few weeks but was unable to provide the surveyor an approximate resignation date. ULP/A-C stated RN-G did a refresher training when she began working late October but was not sure if that refresher training was documented. The licensee's undated 4.05 Employee Records policy, indicated records of all training and in-service education required and/or provided including record of competency testing as required. The policy also indicated licensee would verify completed orientation, annual training, and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440			

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01440	Continued From page 53 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel/house manager (ULP/HM)-B) was supervised within 30 days of being trained for a delegated a nursing tasks by a registered nurse (RN). 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	01440			

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01440	Continued From page 54 situation has occurred only occasionally). The findings include: ULP/HM-B was hired by the licensee on September 27, 2024, to provide assistance to licensee's one resident and managerial duties. ULP/HM-B's [Licensee] Supervision of Home Health Aide: 30 days form dated October 31, 2024, indicated RN-J observed a return demonstration on personal cares and medication administration with R1 and RN-J signed and dated the form. The licensee's daily staff schedule indicated ULP/HM-B worked day shift from 7:00 a.m. to 3:00 p.m. The licensee's March 2025 work schedule dated March 2, through April 2, 2025, indicated ULP/HM-B was scheduled to work Monday through Friday every week on day shift. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a one-time fee to assist. She explained she was not familiar with, and never met ULP/HM-B. She was shocked to find out her name was used to document on employee records. On March 21, 2025, at 10:34 a.m., RN-J provided the surveyor a photo of her written name and signature which did not match the signatures on the above training record. During phone interview on March 21, 2025, at 10:38 a.m., RN-J again explained she assisted	01440			

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01440	Continued From page 55 O/A-K with the provisional assisted living licensure application. She assisted with the paperwork, went through the facility inspection with the inspector, and a few times provided contact information to O/A-K when requested. RN-J also explained she was paid a one-time fee in 2023, but was never hired to be the facility nurse, nor met any of the staff. RN-J also explained she never completed any staff training because she was never employed to complete those tasks. R1's Service Plan (Waiver)-Addendum to Contract signed March 3, 2025, indicated under "Staff Supervision," unlicensed staff are trained by the RN and directly supervised performing delegated tasks. This is completed within 30 days after the date on which the individual begins working for the facility and first performs delegated tasks for resident and thereafter as needed on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors;	01560			

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01560	Continued From page 56 (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. 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: On March 19, 2025, at 9:05 a.m., the surveyor requested the notice of dementia training and unlicensed personnel/administrator (ULP/A)-C stated they may have a dementia training document that employees signed and asked if that was what the surveyor was looking for. At 2:05 p.m., via electronic mail, the surveyor received documentation of unlicensed	01560			

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01560	Continued From page 57 personnel/house manager (ULP/HM)-B's dementia training and a dementia training module titled "Assistance with Activities of Daily Living-3.25 hours." The documents provided did not include the required content. At 3:17 p.m., during phone interview with ULP/A-C, the surveyor requested the required content of the dementia care training notice, and ULP/A-C stated they did not think they had it. The licensee's undated 5.03 Dementia Training policy, indicated the licensee would provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
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	01610			

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01610	Continued From page 58 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 interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) prior to initiation of 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 for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's assisted living contract was signed by R1 on October 1, 2024. R1's Psychiatric Social Work Discharge Note dated October 1, 2024, indicated R1 had been evaluated and treated at an inpatient psychiatry and was stable for discharge.	01610			

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01610	Continued From page 59 R1's admission assessment was completed and electronically signed by registered nurse (RN)-J on October 1, 2024. During interview on March 18, 2025, at 11:24 a.m., R1 stated he signed paperwork upon admission, but did not remember going through the paperwork. He also could not remember if he was assessed by an RN. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a one-time fee to assist. She explained she never admitted any residents for the licensee and was never on their electronic health record (RTasks) which she was not familiar with. She was shocked to find out her name was used to document on resident records. On March 20, 2025, at 12:50 p.m., the surveyor left a voicemail on RN-G's cell phone and attempted to call again at 3:04 p.m., but it went straight to voicemail. The surveyor was unable to interview RN-G to confirm RN-G's employment with licensee before the conclusion of the survey. During phone interview on March 21, 2025, at 1:45 p.m., licensed assisted living director (LALD)-F stated he was not a part of R1's admission and did not know if RN-J was either. He stated he spoke with RN-J over the phone but never met her. The phone connection became impossible to hear so text messaging was initiated. At 2:13 p.m., LALD-F wrote that he did not know if RN-J worked for licensee and was told she was a previous RN. The licensee's undated 6.01 Assessments, Reviews & Monitoring policy, indicated the initial	01610			

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01610	Continued From page 60 nursing assessment must be include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) 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.	01620			

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01620	Continued From page 61 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment 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 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 for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's 14-day assessment completed and electronically signed by RN-J on October 14, 2024. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a one-time fee to assist. She explained she never admitted any residents for the licensee and was never on their electronic health record (RTasks) which she was not familiar with. She was shocked to find out her name was used to document on resident and employee records.	01620			

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01620	Continued From page 62 On March 20, 2025, at 12:50 p.m., the surveyor left a voicemail on RN-G's cell phone and attempted to call again at 3:04 p.m., but it went straight to voicemail. The surveyor was unable to interview RN-G to confirm RN-G's employment with licensee before the conclusion of the survey. During phone interview on March 21, 2025, at 1:45 p.m., licensed assisted living director (LALD)-F stated he was not a part of R1's admission and did not know if RN-J was either. He stated he spoke with RN-J over the phone but never met her. The phone connection became impossible to hear so text messaging was initiated. At 2:13 p.m., LALD-F wrote that he did not know if RN-J worked for licensee and was told she was a previous RN. The licensee's undated 6.01 Assessments, Reviews & Monitoring policy, indicated the initial nursing assessment must be include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730			

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01730	Continued From page 63 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01730			

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01730	Continued From page 64 review, the licensee failed to develop and maintain a current individualized medication management record to include all required content 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 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: During entrance conference on March 17, 2025, at 11:15 a.m., unlicensed personnel/house manager (ULP/HM)-B stated the licensee provided medication management services for R1 and locked R1's medications in a locked box within the kitchen area. At 11:56 a.m., the surveyor observed a kitchen cabinet within the back end of the island where there were two unsecured doors with handles. ULP/HM-B opened the doors and observed a locked black box and a clear Tupperware container containing medications in pharmacy bubble packs sitting directly on the shelf of the cabinet. Behind the black box were additional medications. ULP/HM-B stated the medications outside of the black box were overflow/extra medications and because they couldn't all fit within the locked black box, the cabinet normally was locked. The surveyor did not observe any type of lock nearby nor did ULP/HM-B place a lock on the cabinet after the observation.	01730			

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01730	Continued From page 65 During phone interview at 4:12 p.m., clinical nurse supervisor (CNS)-A stated the medication cabinet doors were never locked because all medications were supposed to be stored within the locked black box. R1 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received assistance with medication administration twice daily and every 21 days. R1's medication administration record for March 2025 indicated R1 received medication administration twice daily and an injection every 21 days. R1's Individualized Medication Management Plan (IMMP) completed by former registered nurse (RN)-G dated December 27, 2024, indicated under medication management that medications were set up by the nurse, nurse would reorder medications according to the cycle medication orders, and controlled substances were secured and stored behind double locks. The RN delegated oral administration task to unlicensed personnel (ULP). Under medication administration, staff would provide medication administration services such as organize and check medication records, prepare medications for administration, check time, route, dose, etc., and R1 needed help with Haldol injection administration (for schizophrenia).	01730			

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NAME OF PROVIDER OR SUPPLIER UNITY HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 767 7TH AVENUE NORTHWEST NEW BRIGHTON, MN 55112			
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01730	Continued From page 66 R1's medication plan lacked the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions (IMMP only talked about controlled medications). On March 20, 2025, at 12:39 p.m., by electronic mail, the licensee indicated RN-G's last day of employment was January 13, 2025. At 12:50 p.m., the surveyor left a voicemail on RN-G's phone. The surveyor attempted another call at 3:04 p.m., but it went right to voicemail. The surveyor was unable to interview RN-G before the survey conclusion. The licensee's undated 7.03 Medication Management Individualized Plan policy, indicated following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following above missing required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:	01750			

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01750	Continued From page 67 (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the unlicensed personnel (ULP) were able to competently follow the procedure, for four of four employees (unlicensed personnel/house manager (ULP/HM)-B, unlicensed personnel/administrator (ULP/A)-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP/HM-B was hired by the licensee on September 27, 2024, to provide assisted living services and managerial duties.	01750			

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01750	Continued From page 68 ULP/A-C was hired on September 30, 2024, to provide assisted living services and administrative duties. ULP-D and ULP-E were hired on September 27, 2024, and September 30, 2024, respectively, to provide assisted living services. During entrance conference on March 17, 2025, at 11:15 a.m., ULP/HM-B stated newly employed staff were trained on medication administration by the nurse. On March 18, 2025, at 8:35 a.m., ULP/HM-B explained R1 had already taken his morning medications but showed the surveyor step by step how she would administer morning medications by pulling out R1's black box and pulling out a bubble card containing a medication and compared it to the electronic medication administration record (eMAR). ULP/HM-B, ULP/A-C, ULP-D, and ULP-E's 2.30 Medication-Oral Meds competency forms dated October 1, 2024, September 30, 2024 (ULP/A-C and ULP-E), and September 27, 2024, respectively, indicated RN-J observed an oral medication administration and signed that each person passed the competency by signing and dating the form. R1's paper MAR dated March 1-7, 2025, and eMAR dated March 7-18, 2025, indicated ULP/HM-B, ULP/A-C, ULP-D, and ULP-E completed R1's medication administration at various times (8:00 a.m. and/or 8:00 p.m.). During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted	01750			

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01750	Continued From page 69 living application and was paid a one-time fee to assist. She explained she never met or trained ULP/HM-B, ULP/A-C, or ULP-D. She was shocked to find out her name was used to document on employee records. During phone interview on March 20, 2025, at 10:34 a.m., clinical nurse supervisor (CNS)-A explained she observed all staff complete medication administration and gave feedback as part of her weekly facility visit. This ensured staff were doing it properly. ULP/HM-B, ULP/A-C, ULP-D, and ULP-E's staff supervision summary completed by CNS-A dated March 6, 2025, March 3, 2025, March 7, 2025, and February 23, 2025, respectively, indicated CNS-A observed oral medication administration and reported no issues. On March 21, 2025, at 10:34 a.m., RN-J provided the surveyor a photo of her written name and signature which did not match the signatures on the above employee records. During phone interview on March 21, 2025, at 10:38 a.m., RN-J again explained she assisted O/A-K with the provisional assisted living licensure application. She assisted with the paperwork, went through the facility inspection with the inspector, and a few times provided contact information to O/A-K when requested. RN-J also explained she was never hired to be the facility nurse, had never met any of the staff. RN-J also explained she never completed any staff training because she was never employed to complete those tasks. The licensee's undated 4.05 Employee Records policy, indicated records of all training and	01750			

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01750	Continued From page 70 in-service education required and/or provided including record of competency testing as required. The policy also indicated licensee would verify completed orientation, annual training, and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document medications administered 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	01760			

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01760	Continued From page 71 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 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received assistance with medication administration. During observation on March 18, 2025, at 8:35 a.m., unlicensed personnel/house manager (ULP/HM)-B demonstrated how she would set up and administer R1's medications by pulling out the locked black box within the kitchen peninsula pulled out a medication bubble pack and compared the resident name, medication name, time, dose, and route to the electronic medication administration record (eMAR). ULP/HM-B demonstrated how she would document each medication on the eMAR. R1's Med Admin Summary (eMAR) dated March 7-19, 2025, indicated the following documentation: -scheduled medications for 8:00 a.m., aripiprazole 5 mg (milligram) for schizophrenia, benztropine mesylate 1 mg for side effects of psychotic medication, and haloperidol 5 mg for	01760			

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01760	Continued From page 72 psychosis were documented outside of the one-hour window (one hour before or after scheduled time) for 9 out of 13 days. -scheduled medications for 8:00 p.m., haloperidol 5 mg, and trazodone hydrochloride 100 mg for sleep were documented outside of the one-hour window for 4 out of 10 days. On March 9, 2025, the eMAR lacked documentation that 8:00 p.m. medications were given to R1 and lacked documentation for the reason why it was not completed. During interview on March 19, 2025, at 11:15 a.m., ULP/HM-B explained R1 consistently asked for his medications on time, and she forgot to document the medication administration right away because R1 distracted her. The licensee's undated 7.22 Medication & Treatment Record- Documentation & Refusal policy, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. The policy also indicated if medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790			

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01790	Continued From page 73 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790			

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01790	Continued From page 74 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for the unlicensed personnel (ULP) providing medications for residents with unplanned time away from home when the licensed nurse was not available for one of one employee (unlicensed personnel/house manager (ULP/HM)-B). 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:	01790			

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01790	Continued From page 75 ULP/HM-B was hired by the licensee on September 27, 2024, to provide assisted living services and managerial duties. During interview on March 18, 2025, at 12:29 p.m., ULP/HM-B stated she was trained to place the medications into an envelope, write the contents on the envelope, and send a copy of the medication administration record (MAR) with the resident. She also indicated she would send enough medications to cover the leave of absence. When asked if there were written procedures available, she stated no, just the information she was taught. ULP/HM-B's training record lacked documentation of training and competency by an RN for providing residents with unplanned time away from home. During phone interview on March 19, 2025, at 3:52 p.m., RN-J stated she only assisted owner/agent (O/A)-K with the provisional assisted living application and was paid a one-time fee to assist. She was not familiar with, and never met ULP/HM-B. She was shocked to find out her name was used to document training and competency on employee records. The licensee's undated 4.05 Employee Records policy, indicated records of all training and in-service education required and/or provided including record of competency testing as required. The policy also indicated licensee would verify completed orientation, annual training, and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790			

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01790	Continued From page 76 days	01790			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on March 17, 2025, at 11:15 a.m., unlicensed personnel/house manager (ULP/HM)-B stated the licensee provided medication management services for R1. During observation on March 18, 2025, at 8:35 a.m., ULP/HM-B demonstrated how she would set up and administer R1's medications by pulling out the locked black box within the kitchen island,	01820			

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01820	Continued From page 77 pulled out a medication bubble pack and compared the resident name, medication name, time, dose, and route to the electronic medication administration record (eMAR). ULP/HM-B demonstrated how she would document each medication on the eMAR. R1 was admitted to licensee for services on October 1, 2024, and had diagnoses including schizophrenia (a mental disorder where the person hears and sees things that are not real), history of laryngeal cancer (cancer of the voice box), and obsessive-compulsive disorder. R1's signed Service Plan (Waiver) - addendum to Contract effective dated March 3, 2025, indicated R1 received assistance with medication administration. R1's eMAR for March 2025, indicated R1 took the following medications: -acetaminophen 325 mg (milligram) tablet, take two tablets (650 mg) by mouth every six hours for pain and fever as needed; -ammonia lactate 12% topical cream, apply to dry skin on arms and back twice daily; -aripiprazole 5 mg tablet by mouth daily for schizophrenia; -benztropine mesylate 1 mg, one tablet by mouth daily for counteracting side effects of psychotic medication; -cholecalciferol 25 mcg (microgram), one tablet by mouth daily for Vitamin D deficiency (on hold); -haloperidol 5 mg, one tablet by mouth twice daily for psychosis; -haloperidol 100 mg/1 ml (milliliter), inject 2 ml intramuscular every three weeks for schizophrenia; -sennosides docusate 8.6-50 mg, one tablet by mouth twice daily for constipation (on hold);	01820			

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01820	Continued From page 78 -trazodone hydrochloride 100 mg, one tablet by mouth at bedtime for sleep; -clonazepam (dose not specified), one tablet twice daily as needed for muscle spasm; and -Urealac 40% topical, apply pea sized amount to thick skin twice daily for dry skin. R1's medications lacked a current written or electronically recorded prescription. During phone interview on March 17, 2025, at 4:12 p.m., clinical nurse supervisor (CNS)-A stated she assisted R1 with coordinating medical appointments, communicated with the pharmacy and matched R1's orders against his medications to ensure they were current. During phone interview on March 20, 2025, at 10:34 a.m., CNS-A explained she had not processed any provider orders since she began employment but sent the medication list to R1's provider and has not received the orders yet. She was not sure if she had seen signed medication prescription in R1's record and assumed there were orders from when he was admitted. During medication reconciliation, she explained she used the pharmacy receipt to compare to R1's current medications. The licensee's undated 7.17 Medication & Treatment Orders-Receiving policy, indicated all orders for medication and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. The content of medication order must contain the name of the drug, dosage, frequency, route, indication and directions for use. Medication orders must be placed in the resident's record.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER UNITY HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 767 7TH AVENUE NORTHWEST NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 79 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. 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 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 March 17, 2025, at 11:15 a.m., unlicensed personnel/house manager (ULP/HM)-B stated the licensee provided medication management services for R1	01880			

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01880	Continued From page 80 and locked R1's medications in a locked box within the kitchen area. During observation at 11:56 a.m., the surveyor observed a kitchen cabinet within the back end of the island where there were two unsecured doors with handles. ULP/HM-B opened the doors and observed a locked black box and a clear Tupperware container containing medications in pharmacy bubble packs sitting directly on the shelf of the cabinet. Behind the black box were additional medications. ULP/HM-B stated the medications outside of the black box were overflow/extra medications and because the medications couldn't all fit within the locked black box, the cabinet was normally locked. The surveyor did not observe any type of lock nearby nor did ULP/HM-B place a lock on the cabinet after the observation. Around 1:00 p.m., the surveyor observed R1 in the kitchen dishing up cottage cheese by himself while ULP/HM-B was sitting in the living room on her computer. There was a floor to ceiling wall that blocked the view of the island from the living room. At 1:12 p.m., the surveyor was sitting at the dining room table next to the kitchen and was facing the kitchen/medication cabinet. The surveyor was doing record review at the table alone and R1 came over and looked in the unlocked medication cabinet then closed it and walked away. R1 did not take anything from the cabinet. During phone interview at 4:12 p.m., clinical nurse supervisor (CNS)-A stated the medication cabinet doors were never locked because all medications were supposed to be stored within the locked black box. When CNS-A was informed	01880			

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01880	Continued From page 81 of the unsecured medications, she explained she would need to retrain all staff as they had been trained to keep all medications within the black box. The licensee's undated 7.11 Medication Storage policy, indicated when medications managed outside of a resident's "living space" must be in a securely locked and substantially constructed compartments and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a	03090			

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03090	Continued From page 82 violation that has not potential to cause more than a minimal impact on the client 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 clients). The finding include: On March 17, 2025, at 11:00 a.m., upon arrival to the licensee's facility, the surveyor did not observe an electronic monitoring notice at the entrance of the facility with the required statutory language. At 1:10 p.m., the surveyor asked unlicensed personnel/house manager (ULP/HM)-B who was responsible for the postings, and she stated unlicensed personnel/administrator (ULP/A)-C was. ULP/HM-B was not aware of the required notice. At 2:18 p.m., during phone interview, ULP/A-C stated she was in charge of revamping the postings on the wall. She thought the electronic monitoring notice was only required if there were cameras in the home but would post the notice. The licensee's undated 2.15 Electronic Monitoring policy, indicated licensee would post a sign at each facility entrance accessible to visitors that states "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

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Type: Full
Date: 03/17/25
Time: 13:15:00
Report: 1005251060

Food and Beverage Establishment Inspection Report

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Location:

UNITY HOMES INC
767 7TH AVENUE NORTHWEST
New Brighton, MN55112
Ramsey County, 62

Establishment Info:

ID #: 0044099
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED EXCLUSION AND RECORDING REQUIREMENTS. BLANK LOG LEFT ON SITE.

Comply By: 03/17/25

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

3-302.11A(1)

**** Priority 1 ****

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

IN THE REFRIGERATOR, RAW SHELL EGGS WERE STORED ABOVE READY-TO-EAT FOODS. MANAGER MOVED EGGS TO THE BOTTOM DRAWER.

Comply By: 03/17/25

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

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

MILK AND OTHER TCS FOODS WERE NOT DATE-MARKED. DISCUSSED MARKING THE DATE THAT FOODS ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS.

Type: Full
Date: 03/17/25
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UNITY HOMES INC

Food and Beverage Establishment Inspection Report

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Comply By: 03/17/25

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 03/24/25

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

MN CFPM CERTIFICATE NOT POSTED ON SITE.

Comply By: 03/24/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

POT ROAST MADE THIS MORNING WAS FOUND COOLING IN THE REFRIGERATOR IN A DEEP, COVERED BOWL. FOOD CANNOT BE PREPARED AHEAD OF TIME WITH CURRENT RESIDENTIAL FRIDGE. INSTRUCTED MANAGER TO SPLIT FOOD INTO SMALLER CONTAINERS AND DISCONTINUE COOLING FOODS.

Comply By: 03/17/25

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 170+ Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/COTTAGE CHEESE

Temperature: 41 Degrees Fahrenheit - Location: LG REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/BEANS

Temperature: 41 Degrees Fahrenheit - Location: LG REFRIGERATOR

Violation Issued: No

Process/Item: Cooling/POT ROAST

Temperature: 64 Degrees Fahrenheit - Location: LG REFRIGREATOR, <6 HOURS

Violation Issued: No

Type: Full
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UNITY HOMES INC

Food and Beverage Establishment Inspection Report

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Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	2	2

INSPECTION COMPLETED WITH HOUSE MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR ANNA BOHEN.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND THEREFOR FOOD MAY BE PREPARED FOR SAME DAY SERVICE ONLY.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 170+ DEGREES F.

CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING IS ACOUSTIC TILE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005251060 of 03/17/25.

Certified Food Protection Manager: MUNTAHA Y. ISSA

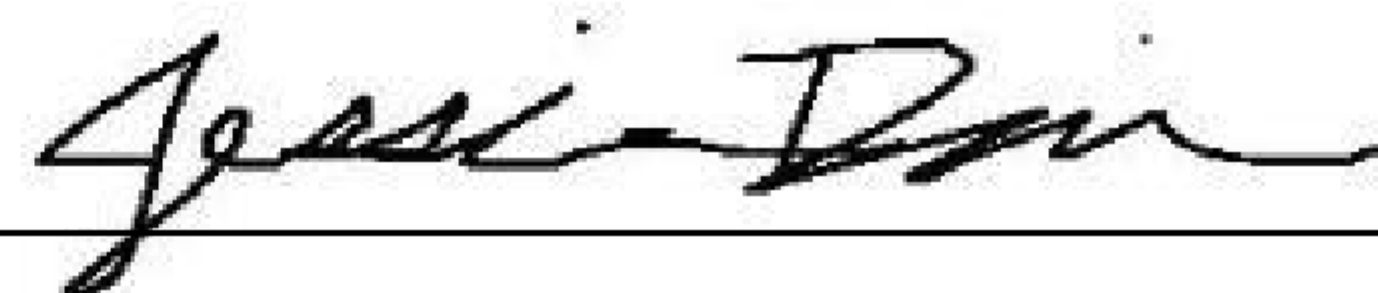
Certification Number: FM121465 Expires: 02/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

TOMICA HORTON
HOUSE MANAGER

Signed: _____



Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us