



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 26, 2026

Licensee

Olydia Home Care Inc

7243 Morgan Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL34307016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 16, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0250 - 144g.20 Subdivision 1 - Conditions - \$500.00

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34307016-0 On January 12, 2026, through January 16, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; all received services under the Assisted Living Facility license.	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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. 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: During the initiation of this survey on January 12, 2025, at 1:12 p.m., registered nurse (RN)-D	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 stated the licensee provided medication and treatment management services and they were familiar with the assisted living regulations. The licensee's Application for Assisted Living License signed on February 28, 2025, section titled Official Verification of Owner or Authorized Agent, (page five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250			

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - 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. - I have examined this application and all attachments and checked the above boxes	0 250			

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0 250	Continued From page 5 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. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner/licensed assisted living director/registered nurse (O/LALD/RN)-J on February 28, 2025. An Assisted Living License was granted to licensee effective March 1, 2025, with an expiration date of February 28, 2026. As a result of this survey, the following orders were issued: 0320, 0340, 0470, 0480, 0650, 0660, 0680, 0730, 0775, 0780, 0790, 0800, 0810, 0910, 0970, 1060, 1290, 1420, 1530, 1640, 1650, 1760, 1770, 1960, 2310, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 320 SS=F	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive	0 320			

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0 320	Continued From page 6 state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide requested necessary staff and facility records to determine compliance with licensure laws and rules. 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 January 12, 2026, at 8:51 a.m., the surveyor	0 320			

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0 320	Continued From page 7 spoke with office support person (SP)-G by telephone who indicated they were a support person at the office, and they confirmed the email on file was correct. On January 12, 2026, at 11:40 a.m., the surveyor contacted SP-G by telephone to ask who would be available to complete the entrance conference, SP-G stated clinical nurse supervisor (CNS)-A would be on site around 2:30 p.m., and registered nurse (RN)-D would be available to complete the entrance conference by telephone. NETSTUDY 2.0 On January 12, 2026, at 2:50 p.m., via email, the surveyor requested the licensee's NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) roster for health facility identification number (HFID) 34307. On January 13, 2026, at 2:35 p.m., via email, the surveyor again requested the licensee's NETStudy 2.0 for HFID 34307. The surveyor had to contact their supervisor to obtain the NETStudy Roster 2.0 in order to continue their document review. DOCUMENTATION OF HOURS WORKED On January 14, 2026, at 9:43 a.m., via email, the surveyor requested documentation of unlicensed personnel hours/days worked for the most recent pay cycle processed. On January 14, 2026, at 11:03 a.m., via email, the surveyor requested documentation of ULP-F's hours/days worked for the most recent pay period (two-weeks) processed.	0 320			

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0 320	Continued From page 8 On January 15, 2026, at 8:20 a.m., via email, the surveyor requested documentation of all ULPs showing hours/days worked for the last pay period (two-weeks) processed. On January 15, 2026, at 4:50 p.m., via email, a final email was sent to licensee requesting documentation of hours/days worked for all direct care staff as requested numerous times. On January 16, 2026, at 11:04 a.m., via email, the surveyor requested the above information to be available by 11:30 a.m., that day. On January 16, 2026, at 11:19 a.m., the surveyor called the same telephone number upon survey initiation by the licensee to get ahold of SP-G where the call went to voicemail. The surveyor left voicemail requesting a call back regarding records. Upon exit conference on January 16, 2026, at 12:45 p.m., the licensee's NETStudy 2.0 roster and documentation of hours worked were not provided to the surveyor. On January 16, 2026, at 8:44 p.m., the licensee sent employee health screening records and indicated "I believe this would be the last of what you asked." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 320			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

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0 340	Continued From page 9 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation taken to comply with the correction orders from a survey completed November 30, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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	0 340			

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0 340	Continued From page 10 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 December 28, 2023, the licensee received results from the previous survey concluded on November 30, 2023. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was January 18, 2024. The licensee lacked documented corrective actions for the following previously cited orders: -0470, 144G.41 Subd.1. Minimum Requirements; -0660, 144G.42 Subd. 9. Tuberculosis prevention and control; -0680, 144G.42 Subd.10. Disaster planning and emergency preparedness plan; -0910, 144G.50 Subd. 2 (a-b). Contract Information; -0970, 144.50 Subd. 5. Waivers of liability prohibited; -1650, 144G.70 Subd. 4 (f). Service Plan, Implementation and Revisions; -1770, 144G.71 Subd. 9. Documentation of Medication Setup; -2310, 144G.91 Subd. 4 (a). Appropriate Care and Services; and -3090, 144G.6502 Subd. 8. Notice to Visitors. Upon survey initiation on January 12, 2026, at 8:51 a.m., via telephone, the surveyor spoke with office support person (SP)-G and they stated the email on file was the correct email to use to send entrance email and document requests.	0 340			

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NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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0 340	Continued From page 11 On January 13, 2026, at 10:03 a.m., licensed assisted living director/registered nurse (LALD/RN)-J responded to a record request email indicating she was working on sending the request which was handed over to clinical nurse supervisor (CNS)-A. This interaction was the only known interaction with LALD/RN-J. Throughout multiple emails, it was unknown who the surveyor was obtaining communication/records from as the email was accessible to multiple staff. On January 15, 2026, at 9:25 a.m., via email, the surveyor requested documented corrections made for survey completed on November 30, 2023. On January 15, 2026, at 4:50 p.m., via email, a final request for multiple documents including the corrections made for survey completed on November 30, 2023. Upon survey completion on January 16, 2026, at 12:45 p.m., the surveyor did not receive documentation of corrections made for survey completed on November 30, 2023. During the survey initiated on January 12, 2026, and exited on January 16, 2026, areas of deficient practice related to tags 0470, 0660, 0680, 0910, 0970, 1650, 1770, 2310, and 3090, were identified and the correction orders were re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

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0 470	Continued From page 12	0 470			
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted with the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect all residents, staff, and visitors.	0 470			

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0 470	Continued From page 13 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living license for a bed capacity of five (5) residents. At the time of the survey, there were three (3) residents; all received services under the Assisted Living Facility license. On January 12, 2026, at 10:15 a.m., the surveyor entered the facility and observed house manager/unlicensed personnel (HM/ULP)-B as the only person working. During observation on January 12, 2026, at 11:18 a.m., HM/ULP-B stated there was no daily staffing schedule posted as they on-boarded a new person to handle scheduling. In the meantime, they used their automatic data processing (ADP) application on their phones to access the schedule. The staffing shift hours were as follows: Day shift: two ULP 6:00 a.m. - 2:00 p.m. Evening shift: two ULP 2:00 p.m. - 10:00 p.m. Night shift: one ULP 10:00 p.m. - 6:00 a.m. On January 12, 2026, at 12:47 p.m., after interviewing R1, the surveyor exited the room and observed ULP-E sitting in the living room. ULP-E stated she was at an appointment and arrived at the facility at noon. On January 12, 2026, at 1:12 p.m., during	0 470			

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0 470	Continued From page 14 entrance conference with registered nurse (RN)-D, stated they updated their staffing plan last month and that staff used ADP to access their schedule. RN-D stated the daily staffing schedule was in the office on the lower level and she had hoped it was not taken down. After the entrance conference, the surveyor observed a daily staff schedule posted in the downstairs office which they used as their medication room which was always locked. The staff schedule was dated July 1, 2024, through August 4, 2024. On January 12, 2026, at 3:18 p.m., clinical nurse supervisor (CNS)-A stated she had completed some cleaning and must have misplaced it. CNS-A began posting different documents up on the wall/white board including the staff schedule. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., the clinical nurse supervisor (CNS) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's 4.06 Staffing & Scheduling policy dated April 29, 2024, noted the 24-hour daily staffing schedule must be posted in a central location accessible to staff, residents, volunteers, and the public and must include direct-care staff work schedules for each direct-care staff member	0 470			

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0 470	Continued From page 15 showing all work shifts, including days and hours worked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480			

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0 480	Continued From page 16 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 are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 480			

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0 480	Continued From page 17 portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 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			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650			

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0 650	Continued From page 18 required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (house manager/unlicensed personnel (HM/ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on January 12, 2026, at 1:12 p.m., registered nurse (RN)-D stated the licensee was aware of the required contents of the employee records. RN-D stated upon hire, staff completed one-on-one training with a nurse, then shadowed other staff, then were signed off by a nurse. Documentation was all done on paper. Then within 90 days, supervisory visits were completed by the nurse. The licensee's employee roster indicated HM/ULP-B, and ULP-C had hire dates of March 13, 2024, and December 1, 2025, respectively. During observation between January 12 through 15, 2026, the surveyor observed HM/ULP-B work all four days during day shift and ULP-C worked two of the four days during day and evening shift	0 650			

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0 650	Continued From page 19 performing multiple tasks. HM/ULP-B On January 14, 2026, at 9:46 a.m., HM/ULP-B stated she was hired around May 7, 2025, not March 2024. HM/ULP-A's record included the following training records: -Orientation Checklist signed by licensed assisted living director/registered nurse (LALD/RN)-J and HM/ULP-B dated May 18, 2025; -undated Vulnerable Adult policy signed by HM/ULP-B; -orientation to two of three current residents care plan starting May 14, 2025; -Certificate of Completion-Competency Evaluation signed by LALD/RN-J on May 14, 2025 (did not specify which competencies); -Certificate of Completion-Medication Administration for Home Health Aides signed by LALD/RN-J on May 18, 2025; and -undated Certificate of Completion-1 hour of Dementia training signed by LALD/RN-J. ULP-C ULP-C's record included the following training records: -Orientation Checklist signed by clinical nurse supervisor (CNS)-A and HM/ULP-B dated November 29, 2025, with a hire date of November 26, 2025 (employee roster indicated December 1, 2025); -orientation to three current residents care plan starting November 28, 2025; -undated Certificate of Completion-Competency Evaluation signed by CNS-A (did not specify which competencies); -undated Certificate of Completion-Infection Prevention and Control signed by CNS-A;	0 650			

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0 650	Continued From page 20 -undated Certificate of Completion-Medication Administration for Home Health Aides signed by CNS-A; and -Certificate of Completion-1 hour of Dementia training signed by CNS-A on November 29, 25 [sic]. HM/ULP-B and ULP-C's record lacked documentation of competency evaluations by a registered nurse as follows: -documentation requirements for all services provided; -appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; -maintenance of a clean and safe environment; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications (did not specify which routes) or treatments as required; -basic knowledge of body functioning; -reading and recording temperature, pulse, and respirations; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -mechanical lifts (sit to stand lift); -oxygen therapy; -catheter care; -ostomy care; -preparation of modified diets as ordered by a licensed health professional; -wound care; and -RN supervision within 30 days of performing	0 650			

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0 650	Continued From page 21 delegated tasks. During observation and interview on January 13, 2026, at 8:35 a.m., ULP-C applied an automatic blood pressure cuff to R3's right arm (upside down) and attempted to get a reading but was getting an error message. ULP-C then adjusted R3's nasal cannula (where one prong should be in each nostril) because the prongs had shifted off R3's nostril. ULP-C then obtained the rest of R3's vital signs (temperature, pulse, and oxygen saturation). ULP-C administered one spray of nasal medication into each nostril. ULP-C stated he was trained in vital signs, oxygen therapy, medication administration, sit to stand lift, and wound care by CNS-A. On January 14, 2026, at 1:15 p.m., CNS-A stated they used the Orientation Checklist to document orientation, then RN-D did skills training but did not know if documentation of skills were completed as it was before her time. At 1:27 p.m., CNS-A explained the certificate for medication competency was documentation of medication training and competency on all routes and certificate of competency was documentation of skills such as treatments and ostomy care, which was done over a period of time. CNS-A stated the certificates would not show which tasks were demonstrated to the RN and located forms they could use going forward. At 2:18 p.m., CNS-A stated she was at the facility often and would watch and observe staff completing tasks and provide redirection when necessary. CNS-A stated she would provide documentation of RN supervision. On January 15, 2026, at 10:48 a.m., via email, the licensee provided ULP-C's Home Health Aide Supervision dated January 14, 2026 (during	0 650			

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0 650	Continued From page 22 survey), documenting various observed tasks on December 2-8, 2025. The licensee's Personnel Records policy dated April 3, 2023, indicated personnel records for an employee shall include records of competency evaluations and supervision. The policy referenced 144A Statute and not 144G Statute. The licensee's 5.10 Training Records policy dated January 1, 2024, indicated the licensee would document the following information for each competency evaluation, training, retraining, and orientation topic: 1. facility name, location, and license number 2. name of training topic or training program 3. the training methodology 4. date of the training and competency evaluation, and total amount of time 5. name and title of instructor, and the instructor's signature 6. name and title of staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training 7. documentation of completed competency evaluation, training, retraining, or orientation would be provided to the employee at the time the evaluation or training was completed No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660			

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0 660	Continued From page 23 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB baseline testing of either a two-step tuberculin skin test (TST) or interferon-gamma release assay (IGRA) blood test for two of two employees (house manager/unlicensed personnel (HM/ULP)-B, ULP-C). 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).	0 660			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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0 660	Continued From page 24 The findings include: The licensee's Facility TB Risk Assessment form was completed on December 8, 2025, identified the facility TB risk level as low. The licensee's employee roster indicated HM/ULP-B, and ULP-C had hire dates of March 13, 2024, and December 1, 2025, respectively. During observation between January 12 through 15, 2026, the surveyor observed HM/ULP-B work all four days during day shift and ULP-C worked two of the four days during day and evening shift. During entrance conference on January 12, 2026, at 1:12 p.m., registered nurse (RN)-D stated staff needed a current TB screening upon hire and could not work with residents if positive. Staff could bring a TB screen from another job as long it was not beyond 90 days or complete a new test before working with residents. On January 13, 2026, at 11:05 a.m., the surveyor sent HM/ULP-B and ULP-C's record request including TB screening to licensee's email. By email after survey completion on January 16, 2026, at 8:44 p.m., the surveyor received some TB records for HM/ULP-B and ULP-C. HM/ULP-B On January 14, 2026, at 9:46 a.m., HM/ULP-B stated she was hired around May 7, 2025, not March 2024. On January 14, 2026, at 11:39 a.m., HM/ULP-B stated she completed a TB gold blood test before	0 660			

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0 660	Continued From page 25 hire and gave the test results to office support staff (SP)-G. By email after survey completion on January 16, 2026, at 8:44 p.m., the surveyor received HM/ULP-B's negative TB QuantiFERON Gold blood test dated November 16, 2024 (beyond 90 days before hire). HM/ULP-B's record included a TB history and symptom screen dated March 18, 2025. ULP-C ULP-C's employee record included documentation of a TB history and symptom screen dated November 27, 2025, but lacked documentation of an actual TB test completed upon hire. The licensee's Tuberculosis Screening/Prevention policy was not provided upon request. The licensee's Personnel Records policy dated April 3, 2023, indicated results of required health screening and medical examinations would be maintained in a separate, private file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW	0 660			

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0 660	Continued From page 26 (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. 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	0 680			

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0 680	Continued From page 27 by: Based on observation, interview, and record review, the licensee failed to complete a written emergency disaster plan with all required content and failed to post the emergency plan prominently. This had the potential to affect all current residents receiving services under the assisted living license, staff, and visitors to the facility. 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 January 12, 2026, at 11:23 a.m., the surveyor observed exit diagrams posted on the wall but could not locate the licensee's emergency disaster preparedness plan (EPP). On January 14, 2026, at 3:13 p.m., clinical nurse supervisor (CNS)-A came up from downstairs (lower level) to provide the surveyor with the licensee's EPP and stated the EPP was stored in the locked office downstairs. The licensee's EPP last reviewed on December 5, 2025, lacked evidence of the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP	0 680			

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0 680	Continued From page 28 officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities (provided an address similar to facility-different house number which did not exist); - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements (documentation of fire drills only). On January 16, 2026, at 12:50 p.m., CNS-A stated she updated the EPP with registered nurse (RN)-D recently and during their quality meetings they had undocumented discussions testing their EPP. They did not have a documented agreement with another facility but stated their alternative location (another single-family home)	0 680			

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0 680	Continued From page 29 would be sufficient. The licensee's Emergency Preparedness policy dated August 1, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also indicated the emergency disaster plan would be prominently posted on each floor of the facility. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=E	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; (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	0 730			

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0 730	Continued From page 30 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. 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 two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 730			

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0 730	Continued From page 31 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 the entrance conference on January 12, 2026, at 1:12 p.m., registered nurse (RN)-D stated the licensee was familiar with the assisted living regulations and provided medication management services to all residents at the facility. R2 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's unsigned service plan with effective date of January 13, 2026, indicated R2 received services including assistance with medication administration, behavior management, nutrition assistance, bathing, catheter care, and transfer assistance using a full body mechanical lift. R2's Service Checkoff List dated January 1-12, 2026, lacked documentation of services provided or refusal on the following services: -January 1 through 12-safety checks (2 times), appointment scheduling (12 times), arranging non-medical transportation (12 times), driver time for appointment (12 times), homemaking (7 times), manage agitation (20 times), manage anxiety (16 times), empty catheter (11 times), shopping (12 times), transfer with full body lift (12 times), blood pressure check (18 times), toileting (17 times), repositioning (17 times), feeding assistance (5 times), dressing (5 times), socialization (two times) and grooming (10 times), shower/bathing assistance (3 times), and bed	0 730			

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0 730	Continued From page 32 bath (two times) at various times of the day. R2's records lacked documentation of the services noted above, or the reason why the service was not provided to R2. R3 R3 was admitted for services on October 2, 2025, and had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. R3's unsigned Service Plan with print date of January 16, 2026, last modified on December 9, 2025, indicated R3 receive services including assistance with medication management, dressing, toileting, oxygen therapy, bathing, and behavior management. R3's Service Checkoff List dated January 1-15, 2026, lacked documentation of services provided or refusal on the following services: -January 1 through 15-seated leg exercises (8 times), appointment scheduling (13 times), arranging non-medical transportation (15 times), bathing assistance (2 times), dressing (2 times), grooming (3 times), homemaking (5 times), shopping (6 times), managing anxiety (12 times), meal preparation (10 times), activity encouragement (5 times), socialization (3 times), and toileting (2 times). R3's records lacked documentation of the services noted above, or the reason why the service was not provided to R3. On January 13, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer nasal spray to R3, obtain vital signs (blood pressure, temperature, pulse, oxygen	0 730			

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0 730	Continued From page 33 saturation, and respirations), and fixed R3's nasal cannula (delivers oxygen via tube) by placing both prongs into R3's nostrils. On January 13, 2026, at 3:15 p.m., ULP-C explained there was no consistent way they documented cares, sometimes the primary person would do all the documentation, and sometimes both staff would document certain tasks. At 4:00 p.m., clinical nurse supervisor (CNS)-A stated the "aide care plan" on Eldermark (electronic health record program) service task would pop up for staff to complete. The licensee's undated 2.37 Resident Record-Documentation policy indicated staff providing assisted living services would document, daily, services provided to resident. All documentation must include the signature and title of the person who performed the services and if service was not performed, staff must document the reason why it was not performed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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, interview, and record review, the licensee failed to ensure the physical	0 775			

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0 775	Continued From page 34 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a	0 780			

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0 780	Continued From page 35 dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 780			

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0 780	Continued From page 36 January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 790			

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0 790	Continued From page 37 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) Days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 38 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810			

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0 810	Continued From page 39 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810			

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0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content, including, in a conspicuous place and manner on the contract, the health facility identification (HFID) of the facility, for one of one resident (R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on October 2, 2025, and began receiving assisted living services. R3's Assisted Living Contract signed on October	0 910			

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0 910	Continued From page 41 2, 2025 (had incorrect physical address of facility), lacked the required HFID number. On January 14, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated it was their process to go over the contract with all residents and [R3's name]'s contract was the contract used for all residents. CNS-A stated R3's contract did not include the HFID for the facility. On January 15, 2026, at 3:57 p.m., via email, CNS-A provided an updated contract for R3 signed by R3's power of attorney on January 15, 2026, which lacked the HFID number, but had correct physical address of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a	0 970			

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0 970	Continued From page 42 resident for one of one resident (R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on October 2, 2025, and began receiving assisted living services. R3's Assisted Living Contract signed on October 2, 2025 (had incorrect physical address of facility), included the following language indicating waiver of liability: "Indemnification: [the licensee's name] shall not be liable for any damage or injury to the resident, or any other person... occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]." On January 14, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated it was their process to go over the contract with all residents and R3's contract was the contract used for all residents. CNS-A also stated they knew there was language indicating waiver of liability in the contract and they needed to be revised. On January 15, 2026, at 3:57 p.m., via email, CNS-A provided an updated contract for R3 signed by R3's power of attorney on January 15, 2026, which included the same waiver of liability	0 970			

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0 970	Continued From page 43 language as the one above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060			

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01060	Continued From page 44 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative and notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of two residents (R2, R3) who were hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's service plan with effective date of January 13, 2026, indicated R2 received services including assistance with medication	01060			

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01060	Continued From page 45 administration, behavior management, nutrition assistance, bathing, catheter care, and transfer assistance using a full body mechanical lift. R2's progress notes dated November 11, 2025, at 6:11 a.m., indicated by unlicensed personnel that R2 complained of breathing difficulties and at 12:30 a.m., emergency services were contacted and R2 was brought to the hospital. R2's progress notes dated November 14, 2025, at 11:25 p.m., clinical nurse supervisor (CNS)-A indicated they were at R2's bedside to assess post-hospitalization due to hypertension (high blood pressure). New order for low sodium diet and blood pressure monitoring every eight (8) hours. R2's medical record lacked documentation a notice was provided to the resident or their designated representative with the following required content: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 46 R3 R3's service plan with effective date of January 16, 2026, indicated R3 received services including assistance with oxygen therapy, bathing, meal preparation, medication administration, and toileting. R3's progress notes dated December 24, 2025, at 4:14 p.m., former nurse (FN)-H indicated R3 returned by ambulance at 3:05 p.m. R3 needed to follow up with urology (deals with urinary tract) in two weeks for possible catheter removal and follow up with primary doctor in 1-2 weeks. R3's progress notes did not include when or why R3 was hospitalized. On January 15, 2026, at 11:28 a.m., via text message, CNS-A stated R3 was sent to the hospital on December 16, 2025. R3's medical record lacked documentation a notice was provided to the resident or their designated representative, and the Office of Ombudsman for Long-Term Care when the resident had not returned to the facility within four days, with the following required content: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060			

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01060	Continued From page 47 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 13, 2026, at 7:34 p.m., via email, CNS-A referenced the licensee's policy, indicating "an emergency relocation is a specific and limited action in which a resident is removed from the facility to another location for housing or services due to urgent medical needs or an imminent risk to the health or safety of others. The policy is clear that an emergency relocation is about temporarily or permanently relocating the resident's place of care, not about obtaining short-term medical treatment." CNS-A then indicated the hospital transfers did not result in a refusal to provide housing or services, it did not trigger a termination, nor did it meet the threshold for an emergency relocation under the policy. The email included a blank "Notice of Emergency Relocation" form with the required information. On January 14, 2026, at 9:28 a.m., via email, regional ombudsman (RO)-I stated they had not received any emergency relocation notices from the facility in the past six (6) months. During interview on January 14, 2026, at 1:03 p.m., after further discussion regarding emergency relocation notices, CNS-A thought emergency relocation notices were given when a resident moved out of the facility and was not aware a notice needed to be sent to OOLTC if a resident did not return to the facility within four (4) days. CNS-A stated R3 was in the hospital for seven (7) days in December 2025. The licensee's Discharge and Transfer of	01060			

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01060	Continued From page 48 Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide written notice to the resident or resident representative, as soon as possible. The policy further indicated the Office of Ombudsman for Long-Term Care would be notified within four days following the emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the current	01290			

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01290	Continued From page 49 health facility identification (HFID) number for one of ten employees (clinical nurse supervisor (CNS)-A) shown to have worked with licensee's 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 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 January 12, 2026, at 1:12 p.m., registered nurse (RN)-D stated clinical nurse supervisor (CNS)-A was the primary nurse for the facility that completed tasks such as medication management and nursing assessments. The licensee's Employee List dated January 12, 2026, indicated CNS-A was hired on November 25, 2025. On January 12, 2026, at 2:50 p.m., via email, the surveyor asked, "who was responsible for conducting background studies for new hires?" The surveyor did not get a response. On January 12, 2026, at 3:15 p.m., CNS-A stated "HR [human resources] was responsible for conducting background studies." On January 12, 2026, at 2:50 p.m., and January 13, 2026, at 2:35 p.m., the surveyor requested the NETStudy 2.0 Roster (web-based system for	01290			

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01290	Continued From page 50 submitting background study requests to the Department of Human Services (DHS)) for HFID 34307. On January 13 and 14, 2026, in the afternoon, the surveyor observed CNS-A at the facility assisting staff and residents and assisting with the survey by providing documents and answering questions. The surveyor had to contact their supervisor to obtain the NETStudy Roster 2.0 to continue their document review. The roster did not list CNS-A being affiliated to HFID 34307. CNS-A's Person Summary provided by surveyor's supervisor indicated CNS-A was affiliated to a homecare agency owned by the same owner under HFID 33618. On January 16, 2026, at 11:19 a.m., the surveyor attempted to reach office support person (SP)-G by telephone and left a message requesting a call back to ask questions including their process for conducting background studies. The surveyor never received a return call. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) last updated October 13, 2025, read, "If you have an existing background study for someone at one facility, you can affiliate the person's background study to another facility if the Sensitive Information Person (SIP) is the same." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01420	Continued From page 51	01420			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to provide training and competency evaluations by a registered nurse (RN) to unlicensed personnel (ULP) for delegated full body mechanical lifts for two of two employees (house manager/ULP (HM/ULP)-B, ULP-C). 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).	01420			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01420	Continued From page 52 The findings include: R2 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's Master Assessment Template dated November 29, 2025, assessed R2 required physical assistance of two people to transfer out of bed using a ceiling lift (motorized full body lift system mounted on a fixed ceiling track allowing for smooth and effortless movement). R2's Home Health Care Plan dated October 1, 2025, indicated R2 received transfer assistance with two people using lift. During observation between January 12 through 15, 2026, the surveyor observed HM/ULP-B work all four days during day shift and ULP-C worked two of the four days during day and evening shift performing multiple tasks. During interview on January 12, 2026, at 11:50 a.m., R2 was lying in their hospital bed watching television. The surveyor observed a ceiling lift within the room. On January 13, 2026, at 9:00 a.m., the surveyor observed R2 lying in bed lying on top of a sling (used with the ceiling lift) and asked why they were lying on it. R2 stated staff used that sling/ceiling lift to scoot them up during repositioning. R2 stated HM/ULP-B and ULP-C (staff working during the interview) were not trained how to put them into the wheelchair using the ceiling lift, but they could instruct HM/ULP-B and ULP-C how to if needed to.	01420			

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01420	Continued From page 53 On January 13, 2026, at 9:05 a.m., HM/ULP-B stated she was trained and had used the ceiling lift once, but ULP-C stated he was never trained on how to use the ceiling lift. On January 13, 2026, at 9:46 a.m., HM/ULP-B stated she was trained how to use the ceiling lift by the former house manager (FHM)-K, but could not recall if she was trained by an RN. Later that day, at 2:00 p.m., during discussion regarding R2's wheelchair (WC), HM/ULP-B stated if the WC was okay to use, the nurse would need to make sure all staff were trained to transfer R2 into the WC using the ceiling lift. On January 13, 2026, at 4:00p.m., CNS-A stated she had never seen R2 out of bed and in their WC. The surveyor asked how ceiling lift training was completed, CNS-A stated licensed assisted living director/RN (LALD/RN)-J trained ULP-C while R2 was at the hospital, so a mannequine was used. Since R2 directed their cares, ULP-C had not had the opportunity to use the ceiling lift enough to get comfortable with it. On January 14, 2026, at 1:15 p.m., during training discussion, CNS-A stated the licensee used a skills checklist where LALD/RN-J performed skills training but CNS-A did not know if HM/ULP-B and ULP-C's skills were completed to show competency because they "were done before her time." On January 14, 2026, at 3:33 p.m., ULP-L stated they were trained to use R2's ceiling lift using two people. Throughout the survey from January 12, through 15, 2026, the surveyor did not observe R2 out of	01420			

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01420	Continued From page 54 bed. The licensee's employee roster indicated HM/ULP-B, and ULP-C had hire dates of March 13, 2024, and December 1, 2025, respectively. On January 14, 2026, at 9:46 a.m., HM/ULP-B stated she was hired around May 7, 2025, not March 2024. HM/ULP-B and ULP-C's training records lacked documentation of training and competency on full body mechanical lifts. The licensee's undated Training Orientation and Competency Evaluations of Home Care Staff policy (policy referenced 144A statutes, but licensee operated under 144G statutes), indicated a registered nurse may delegate tasks only to staff who are competent and possessed the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental	01530			

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01530	Continued From page 55 illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees completed dementia care training (at least eight hours within 160 working hours of the employment start date)	01530			

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01530	Continued From page 56 and two hours of initial training on mental illness and de-escalation topics for two of two employees (HM/ULP-B, ULP-C). 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: The licensee's employee roster indicated HM/ULP-B, and ULP-C had hire dates of March 13, 2024, and December 1, 2025, respectively. Licensee's staff schedule dated December 1, 2025, through January 11, 2026, indicated ULP-C was scheduled for 32 shifts (eight hours each shift). During observation between January 12 through 15, 2026, the surveyor observed HM/ULP-B work all four days during day shift and ULP-C worked two of the four days during day and evening shift performing multiple tasks. HM/ULP-B On January 14, 2026, at 9:46 a.m., HM/ULP-B stated she was hired around May 7, 2025, not March 2024. HM/ULP-B's training record included the following: -one hour of dementia training (introduction and overview) through Educare (online training	01530			

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01530	Continued From page 57 record) completed on November 27, 2025 (over five months after hire date); and -undated Certificate of Completion-one (1) hour of dementia training (topics not specified) signed by licensed assisted living director/registered nurse (LALD/RN)-J. On January 14, 2026, at 11:39 a.m., HM/ULP-B stated she completed dementia training on Educare (5 sections, which 3 of them were about an hour each and the rest were about 30-45 minutes each). HM/ULP-B logged into Educare through licensee's computer and the dementia training showed one hour completed On November 27, 2025. The surveyor asked if she completed dementia training upon hire, she said she did one hour but the rest of her training may have been transferred over from her previous job (could not recall any further details). ULP-C On January 13, 2026, at 3:03 p.m., ULP-C stated his schedule was always Monday through Thursday PM shifts (2:00 p.m. to 10:00 p.m.) and worked Sunday AM (6:00 a.m. to 2:00 p.m.), equaling approximately four (4) to five (5) shifts per week. ULP-C's training record included the following: -two (2) hours of dementia (overview) training on December 10, 2025; and -Certificate of Completion-one (1) hour of dementia training (topics not specified) signed by clinical nurse supervisor (CNS)-A on November 29, 25 [sic]. HM/ULP-B and ULP-C's employee records lacked documentation the required 2 hours of initial training was completed on mental illness and de-escalation topics within 160 hours of start	01530			

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01530	Continued From page 58 date, effective July 1, 2025. In addition, HM/ULP-B and ULP-C's record lacked the required dementia care training (at least eight hours within 160 working hours of the employment start date). On January 14, 2026, between 1:27 p.m.-2:09 p.m., CNS-A stated Educare one (1) hour course "Overview of Mental Health" was assigned to ULP-C but was not completed yet. CNS-A stated she was not aware of any other mental illness courses available. CNS-A completed some dementia training with ULP-C upon hire which took about 2.75 hours and ULP-C had been assigned the rest of the dementia courses on Educare which were not completed yet. On January 16, 2026, at 1:48 p.m., via email, the licensee provided their "Training Orientation and Competency Evaluations of Home Care Staff" which referenced 144A Statute and not 144G Statute. The licensee's undated 5.03 Dementia Training policy indicated all staff were required to complete dementia training at the time of hire and annually thereafter. Direct care employees would complete eight (8) hours of initial training within 160 hours from employment start date. The policy did not include training requirements related to mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 59 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the resident, or their representative, documenting agreement on the services to be provided for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01640			

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01640	Continued From page 60 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: R3 was admitted for services on October 2, 2025, and had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. On January 13, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer nasal spray to R3, obtain vital signs (blood pressure, temperature, pulse, oxygen saturation, and respirations), and fixed R3's nasal cannula (delivers oxygen via tube) by placing both prongs into R3's nostrils. R3's unsigned Service Plan with print date of January 16, 2026, last modified on December 9, 2025, indicated R3 received services including assistance with medication management, dressing, toileting, oxygen therapy, bathing, and behavior management. R3's service plan lacked a signature or other authentication by the resident, or their representative, documenting agreement on the services to be provided. On January 14, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated R3 received a guardian the week prior. While going through admission paperwork, CNS-A felt R3 was not competently understanding the information provided so she stopped providing information, therefore a service plan was not signed. The licensee's Service Plan policy dated April 1,	01640			

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01640	Continued From page 61 2025 (which referenced 144A Statute and not 144G Statute), indicated the initial service plan and any revisions are signed by a representative from [Licensee] and the client [resident] or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650			

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01650	Continued From page 62 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R2, R3) who received 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 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: R2 R2 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's unsigned service plan with effective date of January 13, 2026, indicated R2 received services including assistance with medication administration, behavior management, nutrition assistance, bathing, catheter care, and transfer assistance using a full body mechanical lift. R3 R3 had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring	01650			

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01650	Continued From page 63 of lung tissue) and chronic constipation. R3's unsigned service plan with effective date of January 16, 2026, indicated R3 received services including assistance with oxygen therapy, bathing, meal preparation, medication administration, and toileting. On January 13, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer nasal spray to R3, obtain vital signs (blood pressure, temperature, pulse, oxygen saturation, and respirations), and fixed R3's nasal cannula (delivers oxygen via tube) by placing both prongs into R3's nostrils. On January13, 2026, at 4:00 p.m., the surveyor had requested the signed service plan and clinical nurse supervisor (CNS)-A asked if the form "6790" was the service plan. The surveyor explained further the service plan was an agreement between the licensee and the resident. R2 and R3's service plans lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650			

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01650	Continued From page 64 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On January 16, 2026, at 12:50 p.m., CNS-A stated licensed assisted living director/registered nurse (LALD/RN)-J had updated documents such as the contract and thought the missing service plan content would be within the contract. The licensee's Service Plan policy dated April 1, 2025 (which referenced 144A Statute and not 144G Statute), indicated the service plan included the following: a. A description of the home care [assisted living] services to be provided b. The fees for services and the frequency of each service c. Identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the client [resident] e. The schedule and methods of monitoring staff providing home care services [assisted living services] f. A contingency plan No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 65 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 document administration of medications according to provider orders for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 the entrance conference on January 12, 2026, at 1:12 p.m., registered nurse (RN)-D stated the licensee was familiar with the assisted living regulations and provided medication management services included weekly	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
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01760	Continued From page 66 medication setup by the RN to all residents at the facility. R2 R2 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's unsigned service plan with effective date of January 13, 2026, indicated R2 received services including assistance with medication administration, behavior management, nutrition assistance, bathing, catheter care, and transfer assistance using a full body mechanical lift. R2's Master Assessment Template dated November 29, 2025, indicated licensee's staff managed R2's medications. On January 12, 2026, at 2:36 p.m., the surveyor requested R2's January Medication Administration Record (MAR) and provider orders but they were not provided. R2's MAR dated December 2025, included the following documentation: -albuterol-ipratropium (lowers blood pressure) 2.5-0.5 milligrams (mg)/3 milliliter (ml) inhale every four (4) hours daily at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.- given 11 out of 186 occurrences; -arginine powder (assists with wound healing), mix one pack in liquid by mouth twice daily- given 2 out of 62 occurrences; -baclofen 20 mg (treat muscle spasticity), give two tablets by mouth daily and one tablet by mouth twice daily- given 43 out of 62 occurrences; -budesonide 0.5 mg/2ml (treats inflammation),	01760			

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01760	Continued From page 67 inhale 2 ml via nebulizer twice daily, given 4 out of 62 occurrences; -cadexomer iodine 0.9% gel (antiseptic disinfectant), given 2 out of 31 occurrences; -escitalopram oxalate 30 mg (antidepressant), give one tablet daily, given 22 out of 31 occurrences; -ferosul 325 mg (iron supplement), give one tablet by mouth daily, given 23 out of 31 occurrences; -fluticasone furoate 50 micrograms (mcg) (for runny nose), inhale two sprays to both nostrils daily, given 4 out of 31 occurrences; -furosemide 40 mg (diuretic), give one tablet by mouth daily, given 23 out of 31 occurrences; -losartan 50 mg (lowers blood pressure), one tablet by mouth daily, given 23 out of 31 occurrences; -multivitamin tablet, give one tablet by mouth daily, given 23 out of 31 occurrences; -nystatin powder (fungal infection), one strip topically to affected area twice daily, given 10 out of 62 occurrences; -pantoprazole sodium 20 mg (acid reflux), give one tablet by mouth daily before a meal, given 23 out of 31 occurrences; -potassium chloride extended release 10 milliequivalent (meq) (supplement), give one tablet by mouth twice daily, given 51 out of 62 occurrences; -pregabalin 300 mg (anticonvulsant), give one capsule by mouth twice daily, given 51 out of 62 occurrences; -sennosides 8.6 mg (stool stimulant), give one tablet by mouth with lunch, given 24 out of 31 occurrences; -tenofovir 300 mg (antiviral), give one tablet by mouth daily, given 23 out of 31 occurrences; -trazodone 150 mg (sleep aid) tablet, give one tablet by mouth at bedtime, given 27 out of 31	01760			

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01760	Continued From page 68 occurrences; -vitamin c 500 mg, give one tablet by mouth daily, given 23 out of 31 occurrences; and -Xarelto 20 mg (anticoagulant), give one tablet by mouth daily, given 16 out of 31 occurrences. On January 13, 2026, at 1:45 p.m., the surveyor observed HM/ULP-B pour medications from a pill box and administer senna and baclofen to R2. R3 R3 had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. R3's unsigned Service Plan with print date of January 16, 2026, last modified on December 9, 2025, indicated R3 receive services including assistance with medication management, dressing, toileting, oxygen therapy, bathing, and behavior management. R3's Master Assessment Template dated December 24, 2025, indicated R3 received assistance with medication management. On January 13, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer Fluticasone nasal spray to R3. R3's MAR dated January 1-14, 2026, included the following documentation: -CertaVite senior (multivitamin), one tablet by mouth daily, given 12 out of 14 occurrences; -citalopram 10 mg (antidepressant), give two tablets by mouth daily, given 12 out of 14 occurrences; -famotidine 10 mg (for acid reflux), give one tablet by mouth daily, given 22 out of 24 occurrences; -fluticasone propionate 50 mcg (for runny nose),	01760			

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01760	Continued From page 69 inhale two sprays into both nostrils daily, given 12 out of 14 occurrences; -prednisone 5 mg (for inflammation), give one tablet by mouth daily, given 13 out of 14 occurrences; -senna 8.6 mg, give two tablets by mouth daily, given 11 out of 14 occurrences; and -tamsulosin 0.4 mg (promotes urine flow), give two capsules by mouth daily, given 10 out of 14 occurrences. R3's After Visit Summary (AVS) dated January 8, 2026, indicated R3 was ordered to take the above medications listed on the MAR. During interview on January 13, 2026, at 10:49 a.m., house manager/unlicensed personnel (HM/ULP)-B stated R2 refused his nebulizer, notified the registered nurse (RN) about the refusals, but it still showed on the MAR. HM/ULP-B explained if a resident refused medications, they would document the refusal by making a note and would show a circle around their initials. On January 14, 2026, at 3:13 p.m., clinical nurse supervisor (CNS)-A stated she was not familiar with the MAR format and did not know what the blank boxes meant but had contacted the clinic regarding R2 refusing his nebulizer treatment. CNS-A checked the pill boxes to ensure medications were being given. CNS-A also stated staff were trained to check the medication against the MAR before administering and document when a medication was not available on the MAR. The licensee's undated 7.22 Medication & Treatment Record-Documentation & Refusal policy, indicated the licensee would create and maintain a correct and accurate medication	01760			

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01760	Continued From page 70 record for each resident receiving medication assistance or administration. If medication administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. To indicate the medication was refused, circle initials and write a capital R in the same box on the MAR. If the medication was held, circle initials and write a capital H in the same box on the MAR. Reason for refusal and held should be documented under "special remarks." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01770			

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01770	Continued From page 71 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 the entrance conference on January 12, 2025, at 1:12 p.m., registered nurse (RN)-D stated the nurse completed medication set up weekly for all residents that receive medication administration. R2 R2 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's unsigned service plan with effective date of January 13, 2026, indicated R2 received assistance with medication administration. R2's signed provider orders were requested. The licensee only provided the medication list. R2's record lacked medication setup documentation to include dates of medication setup. R3 R3 had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. R3's unsigned service plan with effective date of January 16, 2026, indicated R3 received assistance with medication administration. R3's unsigned After Visit Summary (AVS) dated	01770			

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01770	Continued From page 72 October 23, 2025, indicated the following: -sennoside 8.6 milligram (mg) tablet, take two tablets daily for constipation; and -tamsulosin 0.4 mg capsule, take two (2) capsules by mouth daily after a meal for benign enlargement of prostate. R3's medication administration record (MAR) dated January 2026, indicated the same information for senna and tamsulosin as the AVS. R3's record lacked medication setup documentation to include dates of medication setup, the quantity of doses for senna and tamsulosin, how many days the medications were set up for. On January 14, 2026, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated during medication set up, she was taught to use the resident's medication list that included all scheduled and as needed medications and compare that to the resident's medication administration record (MAR) to ensure the information was the same. Once completed, she wrote notes on the medication list itself if something was not set up or if a medication refill was requested. On January 16, 2026, at 12:50 p.m., CNS-A confirmed she set up two capsules of tamsulosin and two tablets of senna each week but stated the documentation did not reflect that. The licensee's undated 7.22 Medication & Treatment Record-Documentation & Refusal policy indicated the licensee would create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration.	01770			

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01770	Continued From page 73 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were documented accurately in the record for one of one resident (R1) receiving oxygen therapy. 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:	01960			

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01960	Continued From page 74 R3 had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. R3's unsigned Service Plan with print date of January 16, 2026, last modified on December 9, 2025, indicated R3 received services including assistance with medication management, dressing, toileting, oxygen therapy, bathing, and behavior management. R3's Master Assessment Template dated October 3, 2025, indicated R3 received full assist with oxygen. On January 13, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer a nasal spray to R3 and fixed R3's nasal cannula (delivers oxygen via tube) by placing both prongs into R3's nostrils. The surveyor observed an oxygen concentrator (machine that concentrates ambient air to deliver more pure oxygen) with flow rate of 2 liters of oxygen per minute. R3's provider orders dated October 2, 2025, ordered continuous oxygen at 2 liters per minute via nasal cannula. R3's Service Checkoff List dated December 1, 2025, through January 15, 2026, included the following: -"Other Delegated Task-Staff administers oxygen to client continuously. Staff assist in monitoring client's vital signs daily and spot check client's oxygen saturation 3 times daily," documented given by initialing 13 out of 46 occurrences; and -"Other Delegated Tasks-Change nexal [sic] cannula weekly on Thursday AM (morning),"	01960			

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01960	Continued From page 75 documentation given by initialing 0 out of 6 occurrences. R3's medical record lacked accurate documentation of oxygen therapy being provided. On January 13, 2026, at 3:15 p.m., ULP-C explained there was no consistent way they documented cares, sometimes the primary person would do all the documentation, and sometimes both staff would document certain tasks. At 4:00 p.m., clinical nurse supervisor (CNS)-A stated the "aide care plan" on Eldermark (electronic health record program) service task would pop up for staff to complete. The licensee's undated 7.22 Medication & Treatment Record-Documentation & Refusal policy indicated the licensee would create and maintain a correct and accurate medication record for each resident receiving treatment/therapy assistance or administration. If treatment/therapy administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. To indicate the treatment/therapy was refused, circle initials and write a capital R in the same box on the MAR. If the treatment/therapy was held, circle initials and write a capital H in the same box on the MAR. Reason for refusal and held should be documented under "special remarks." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

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02310	Continued From page 76	02310			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R2, R3) who utilized hospital side rails. 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: R2 On January 12, 2026, at 11:50 a.m., during interview with R2, the surveyor observed raised bilateral hospital style side rails on R2's hospital bed. R2 explained he had never seen a nurse come in to observe his side rails, nor seen anyone complete measurements. R2 also explained he had been in bed since his fall during summer time. R2 was admitted for services on July 8, 2022,	02310			

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02310	Continued From page 77 had diagnoses including quadriplegia (symptom of paralysis that affects all person's limbs and body from neck down) and spinal cord injury at C5-C7 (cervical spine). R2's unsigned service plan with effective date of January 13, 2026, indicated R2 received services including assistance with medication administration, behavior management, nutrition assistance, bathing, catheter care, and transfer assistance using a full body mechanical lift. R2's [Licensee] Side-Rail Use Assessment Form dated July 8, 2022, included the following information: -assessment for side rail use; -interventions to reduce risk of injury with side rail use; and -acknowledgement of risks vs benefit. R2's Master Assessment Template dated November 29, 2025, November 17, 2025, and May 23, 2025, respectively, indicated R2 utilized side rails for bed mobility, but did not include any additional information. R3 On January 12, 2026, at 10:40 a.m., the surveyor observed raised hospital style bilateral side rails on R3's hospital bed while R3 was in bed. R3 was admitted for services on October 2, 2025, and had diagnoses including interstitial pulmonary disease (inflammation and progressive scarring of lung tissue) and chronic constipation. R3's unsigned Service Plan with print date of January 16, 2026, last modified on December 9, 2025, indicated R3 received services including assistance with medication management,	02310			

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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
02310	Continued From page 78 dressing, toileting, oxygen therapy, bathing, and behavior management. R3's Side Rail Use Assessment Form completed by owner/licensed assisted living director/registered nurse (O/LALD/RN)-J dated October 2, 2025, included the following information: -assessment for side rail use; -interventions to reduce risk of injury with side rail use; and -documentation of risk versus benefit discussion with resident/or family. R3's [Licensee] Side-Rail Use Assessment Form completed by clinical nurse supervisor (CNS)-A dated October 2, 2025, included the following information: -assessment for side rail use; -recommended bilateral side rail use; -interventions to reduce risk of injury with side rail use; and -overall dimensions of side rail and width between the bars within the side rail, and indicated staff were able to use side rail without difficulties. R2 and R3's medical record lacked documentation of the following required information: -documentation of actual measurements for R2 and R3's side rails safety zones one through five; -an assessment completed at least every 90 days or with a change in condition; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. During interview on January 14, 2026, at 2:18 p.m., CNS-A stated measurements were done with every 90 day or change in condition	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 79 assessment, and that she had completed R3's side rail assessment upon admission. She was instructed by O/LALD/RN-J to write down the measurements, but she had not completed any side rail assessments for R2 since she began employment with licensee. CNS-A also explained she would make sure the side rails were functioning, educated staff on how to use side rails correctly and check for "tightness." During interview on January 16, 2026, at 12:48 p.m., CNS-A stated she was shown how to measure the height of the mattress to the railing, the bed to the railing, and those measurements would be done upon initial use, then for reassessments, she would check side rails for stability. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 13, 2025, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 80 assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." "Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 81 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 and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at 11:23 a.m., the surveyor observed all the entrances of the facility and was unable to locate the required notice. On January 12, 2026, at 3:18 p.m., clinical nurse supervisor (CNS)-A stated she had completed some cleaning and must have misplaced it. CNS-A began posting documents up on the wall/white board. Upon survey completion, the electronic monitoring notice was not posted. The licensee's blank Assisted Living Contract dated 2021, indicated under "Primary Services #	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 82 12. Electronic Monitoring: a. "Information about electronic monitoring is posted at each entrance accessible to visitors." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

OLYDIA HOME CARE INC
7243 MORGAN AVENUE NORTH
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34307

Risk:
License:
Expires on:
CFPM: Lydia Bi Nkwonkam
CFPM #: 62084; Exp: 09/29/2028

Inspection Info

Report Number: F1021261007
Inspection Type: Full - Single
Date: 1/13/2026 Time: 10:42:59 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 4
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: NO THIN PROBE FOOD THERMOMETER WAS AVAILABLE ON-SITE. PROVIDE A THIN PROBE FOOD THERMOMETER AS REQUIRED BY THE RULE ABOVE. THERMOMETER PROBE SANITATION WAS DISCUSSED.

Comply By: 1/19/2026 Originally Issued On: 1/13/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. ONE THERMOLABEL LEFT ON-SITE. PROVIDE.

Comply By: 1/20/2026 Originally Issued On: 1/13/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. DISCUSSED THE APPROVED FOOD CONTACT SURFACE SANITIZERS AND THEIR APPROPRIATE TEST KITS. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 1/19/2026 Originally Issued On: 1/13/2026

New Order: 4-300 Equipment Numbers and Capacities

4-303.11B *Priority Level: Priority 3 CFP#: 48*

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

COMMENT: ESTABLISHMENT DID NOT HAVE AN APPROVED SANITIZER ON-SITE. CLEANERS WERE AVAILABLE; HOWEVER, THEY ARE NOT APPROVED FOR USE ON FOOD CONTACT SURFACES. STAFF WILL OBTAIN AN APPROVED SANITIZER FOR KITCHEN USE. A FACT SHEET LISTING APPROVED FOOD CONTACT SURFACE SANITIZERS WAS PROVIDED WITH THE REPORT.

Comply By: 1/13/2026 Originally Issued On: 1/13/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.11 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

COMMENT: THE HAND SOAP DISPENSER AT THE KITCHEN HANDWASHING SINK WAS FOUND EMPTY. STAFF HAD A CONTAINER OF DISH SOAP AVAILABLE; HOWEVER, THEY REPORTED BEING UNABLE TO REFILL OR REPLACE THE DISPENSER BECAUSE THE KEY IS MAINTAINED BY THE NURSE. ENSURE THAT AN ADEQUATE SUPPLY OF HAND SOAP IS AVAILABLE AT ALL TIMES AT HANDWASHING SINKS.

Comply By: 1/13/2026 Originally Issued On: 1/13/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: THE HANDWASHING SINK IN THE KITCHEN WAS MISSING A HANDWASHING SIGN OR POSTER REMINDING FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE SIGNAGE AS REQUIRED BY THE RULE ABOVE.

Comply By: 1/15/2026 Originally Issued On: 1/13/2026

Food & Beverage General Comment

All findings on this report were discussed with House Manager, Amiah Tyler and Health Regulation Division Nurse Evaluator, Anna Bohnen.

This facility is a residential home, and they currently have 3 client and the facility can accommodate up to 5 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

The kitchen has residential equipment, wood cabinets, laminate countertops and painted drywall. Physical facility items will be monitored during future inspections.

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

I acknowledge receipt of the Metro District Office inspection report number F1021261007 from 1/13/2026

Melissa Ramos

Amiah Tyler
House Manger

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

OLYDIA HOME CARE INC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1021261007
Inspection Type: Full
Date: 1/13/2026
Time: 10:42:59 AM

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

Location: GE Kitchen Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

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

Location: GE Kitchen Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** GE Kitchen Refrigerator ; **Temperature Process:** Ambient Air

Location: GE Kitchen Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

OLYDIA HOME CARE INC
7243 MORGAN AVENUE NORTH
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34307

Risk:
License:
Expires on:
CFPM: Lydia Bi Nkwonkam
CFPM #: 62084; Exp: 09/29/2028

Inspection Info

Report Number: F1021261033
Inspection Type: Follow-up - Single
Date: 1/27/2026 Time: 10:40:13 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Today's follow-up was to address and clear previously written orders from a full inspection conducted on 01/13/26. 6 out of 6 orders were cleared from the report.

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

I acknowledge receipt of the Metro District Office inspection report number F1021261033 from 1/27/2026

Amiah Tyler
House Manager

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL34307016-0	Date: 1/13/2026
Facility Name: OLYDIA HOME CARE INC	
Facility Address: 7243 Morgan Ave N, Minneapolis, Minnesota 55430	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A working space of not less than 30 inches (762 mm) in width, 36 inches (914 mm) in depth and 78 inches (1981 mm) in height shall be provided in front of electrical service equipment. Where the electrical service equipment is wider than 30 inches (762 mm), the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: The electrical panel was blocked and inaccessible.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or another emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: The egress window in resident room #5 was concealed with a pull-down style projector screen.

4. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

Comments: Resident room 1 was missing outlet covers

5. Compressed gas containers shall be stored in an upright position with the valve end up. Cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3; MSFC 5304.1]

Comments: A number of oxygen tanks were observed unsecured and laying on the ground and not in approved storage racks.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The main level hallway, leading to the resident rooms, was missing an interconnected smoke alarm.

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

Comments: Two separate smoke alarm systems were installed, but each separate system was not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: The service tag on the fire extinguisher indicated the last annual service was in 2023.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The egress window in resident room 2 would not fully close and would not lock.

The brick at the base of the front entrance was missing and the wood was degrading from weather exposure.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The reviewed staff fire policy was from a third party and did not include specifics of the facility.

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

Comments: House manager/ unlicensed personnel (HM/ULP)-B stated she was not familiar with a resident fire policy.

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

Comments: HM/ULP-B stated that staff training was done in a third-party online platform and was not on the licensee's facility specific FSEP.

4. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: HM/ULP-B stated that resident training was not provided to the residents.

5. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Review of the facility fire drill log indicated evacuation drills were completed on 1/22/25, 5/5/25, and 12/5/25.