



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 21, 2026

Licensee
Tranquil Living
2521 Wilshire Boulevard
Mound, MN 55364

RE: Project Number SL34050016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 29, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

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March 3, 2026

Licensee
Tranquil Living
2521 Wilshire Boulevard
Mound, MN 55364

RE: Project Number(s) SL34050016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 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 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEpHVva>. 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,

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

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER TRANQUIL LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 WILSHIRE BOULEVARD MOUND, MN 55364			
(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: SL34050016-0 On January 26, 2026, through January 29, 2026, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents: all of whom were receiving services under the Assisted Living 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the	0 330			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH) during a survey. The licensee provided the surveyor with falsified back dated nursing assessments. 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 27, 2026, at 7:21a.m., via email, the surveyor requested a copy of R1's record including R1's initial nursing assessment, 14-day assessment, and the three most recent 90-day assessments from the licensee. On January 27, 2026, at 1:11 p.m., the surveyor sent another email to clinical nurse supervisor/licensed assisted living director	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 (CNS/LALD)-D to provide R1's documents requested at 7:21 a.m. At 1:27 p.m., CNS/LALD-D provided partial documents. At 2:26 p.m., via email, the surveyor requested R2's assessments and highlighted the missing documents from R1's record and requested CNS/LALD-D to provide the documents by 4:30 p.m. At 5:34 p.m., and 5:35 p.m., CNS/LALD-D provided more records for R1 and R2 via email. The email received on January 27, 2026, at 1:27 p.m., contained three 90-day assessments for R1 which appeared to be completed using Residex (electronic medical record software) on the following dates: - June 10, 2025; electronically signed by LALD/CNS on 6/10/25 at 5:17 p.m. - September 10, 2025; electronically signed by LALD/CNS on 9/10/25 at 10:17 p.m.; and - December 10, 2025; electronically signed by LALD/CNS on 12/10/25 at 10:17 p.m. The email received on January 27, 2026, at 5:35 p.m., contained two 90-day assessments for R2 which appeared to be completed using Residex on the following dates: - July 23, 2024; electronically signed by LALD/CNS on 7/23/24 at 7:11 p.m.; and - July 23, 2025; electronically signed by LALD/CNS on 7/23/25 at 7:11 p.m. On January 28, 2026, at approximately 12:15 p.m., CNS/LALD-D stated they did not have an admission or 14-day assessment for R2 and stated it was an oversight. The surveyor then requested R3's assessments. CNS/LALD-D stated the assessments for R3 were at their house. The surveyor asked CNS/LALD-D to print the documents directly from Residex and email them to the surveyor. CNS/LALD-D stated they	0 330			

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0 330	Continued From page 3 did not use Residex. The surveyor showed the trademark "© 2025 TenX Systems, LLC dba Residex" on the bottom pages of R1's assessments to CNS/LALD-D and questioned why the trademark was there if they did not use Residex to do the assessments. CNS/LALD-D stated, they sometimes used Residex to complete assessments. The surveyor asked CNS/LALD-D what other method they had used to complete resident assessments. CNS-LALD-D did not answer the surveyor's questions, but directed one of the licensee's unlicensed personnel (ULP) to their home to gather assessments and stated their house was five minutes away. A few minutes later, the surveyor observed and overheard CNS/LALD-D speaking on the phone and directing the person on the other end of the line of places to look for assessments. The licensee did not produce any additional paper assessments. On January 28, 2026, at 12:39 p.m., CNS/LALD-D stated they missed doing R3's assessments. CNS/LALD-D stated they were cited for not having R3's admission assessment following a previous survey (concluded on March 21, 2024), and they completed only one assessment for R3 in year 2024, and "I completely overlooked, and he only has one assessment." On January 28, 2026, at 12:50 p.m., CNS/LALD-D stated their understanding of the required nursing assessment completion timeline was to complete nursing assessments once a year for each resident. The surveyor then inquired to see resident assessment reports (history of previously completed assessments) on Residex. CNS/LALD-D signed into Residex and the surveyor observed the following information as	0 330			

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0 330	Continued From page 4 CNS/LALD-D navigated through the Residex system: R1's assessment history indicated the following: <table><tr><td>Assessment Type</td><td>Assessment Date</td></tr><tr><td>Assessment Completed By</td><td></td></tr><tr><td>Individual Review</td><td>9/15/23</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Admission</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Dietary Preferences</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Resident Bio / History</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Individual Review</td><td>4/19/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Admission</td><td>1/26/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Dietary Preferences</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>MAHC 10 (Fall Risk)</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Individual Review</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr></table> R1's Rexitdex assessment history did not include R1's assessments provided by CNS/LALD-D for the completion dates of June 10, 2025; September 10, 2025; and December 10, 2025. R2's assessment history indicated the following: <table><tr><td>Assessment Type</td><td>Assessment Date</td></tr><tr><td>Assessment Completed By</td><td></td></tr><tr><td>Admission</td><td>1/26/26</td></tr><tr><td>CNS/LALD</td><td></td></tr><tr><td>Admission</td><td>1/26/26</td></tr><tr><td>CNS/LALD</td><td></td></tr><tr><td>Dietary Preferences</td><td>1/26/26</td></tr><tr><td>CNS/LALD</td><td></td></tr></table>	Assessment Type	Assessment Date	Assessment Completed By		Individual Review	9/15/23	CNS/LALD-D		Admission	4/18/24	CNS/LALD-D		Dietary Preferences	4/18/24	CNS/LALD-D		Leisure Activity Inventory	4/18/24	CNS/LALD-D		Leisure Activity Inventory	4/18/24	CNS/LALD-D		Resident Bio / History	4/18/24	CNS/LALD-D		Individual Review	4/19/24	CNS/LALD-D		Admission	1/26/26	CNS/LALD-D		Dietary Preferences	1/27/26	CNS/LALD-D		Leisure Activity Inventory	1/27/26	CNS/LALD-D		MAHC 10 (Fall Risk)	1/27/26	CNS/LALD-D		Individual Review	1/27/26	CNS/LALD-D		Assessment Type	Assessment Date	Assessment Completed By		Admission	1/26/26	CNS/LALD		Admission	1/26/26	CNS/LALD		Dietary Preferences	1/26/26	CNS/LALD		0 330			
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0 330	Continued From page 5 Leisure Activity Inventory 1/26/26 CNS/LALD Individual Review 1/27/26 CNS/LALD R2's Residex assessment history did not include R2's assessments mentioned above and provided by CNS/LALD-D for the completion dates of July 23, 2024, and July 23, 2025. On January 28, 2026, at 1:30 p.m., the surveyor asked CNS/LALD-D where the provided assessments originated from since they were not included on the resident's assessment history list. CNS/LALD-D stated, "I copy and paste them, I copied it from the most recent one." CNS/LALD-D stated for R2, they copied and pasted information from the January 26, 2026, assessment (conducted during the survey) and back dated it. The surveyor asked CNS/LALD-D if they understood that doing so was falsification of documentation. CNS/LALD-D stated, "Now that you explain it; yes". CNS/LALD-D stated they did not have any other assessments on paper other than the documents they had already provided to the surveyor, and the same was true for all residents. On January 29, 2026, at 12:52 p.m., the surveyor asked CNS/LALD-D to clarify, when they said they "copy and pasted", what exactly they did. CNS/LALD-D stated, "copy pasted to word document and changed the date". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			

Minnesota Department of Health

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0 340	Continued From page 6	0 340			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever 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 have sufficient documentation with actions taken to comply with correction orders (tag identification: 1380, 1470, 1530, 1620) for a survey completed on March 21, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 340			

Minnesota Department of Health

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0 340	Continued From page 7 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 the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. The licensee lacked documentation of their actions taken to comply with correction orders previously cited following a survey concluded on March 21, 2024. On January 29, 2026, at approximately 12:35 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they did try to make the corrections but they failed. Correction orders with tag identifiers 1380, 1470, 1530, and 1620 were re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 470 SS=F	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	0 470			

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0 470	Continued From page 8 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 develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. In addition, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required. This had the potential to affect all residents, staff, and visitors.	0 470			

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0 470	Continued From page 9 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 held an assisted living license. The facility was licensed for a capacity of five residents and during the survey had a census of four residents. During the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. POSTING On January 26, 2026, at 11:00 a.m., during a facility tour, the surveyor observed no staffing schedule posted anywhere in the facility. On January 26, 2026, at approximately 11:00 a.m., unlicensed personnel (ULP)-A stated employee schedules were not posted anywhere in the building, and ULP have their schedules on their phones. On January 26, 2026, at 11:55 a.m., CNS/LALD-D stated they were aware of the requirement to post the staffing schedules, but they did not post the staffing schedule to avoid mix ups. CNS/LALD-D stated they sent the	0 470			

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0 470	Continued From page 10 schedules directly to the employees. STAFFING PLAN On January 29, 2026, at 12:40 p.m., CNS/LALD-D stated they did not have a staffing plan. CNS/LALD-D stated, "I have a policy, but I have not fully implemented." The licensee's 4.06 Staffing and Scheduling policy dated October 12, 2023, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work schedule must be posted, after redacting 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 facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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;	0 650			

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0 650	Continued From page 11 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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: ULP-B ULP-B was hired on January 1, 2020, to provide direct care services to residents.	0 650			

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0 650	Continued From page 12 ULP-E ULP-E was hired on June 10, 2023, to provide direct care services to residents. ULP-F ULP-F was hired on March 18, 2024, to provide direct care services to residents. ULP-B, ULP-E, and ULP-F's employees recorded lacked documentation of training for unplanned times away medication preparation. On January 28, 2026, at 12:10 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the ULPs would prepare medication in case of residents leaving for unplanned times away from the facility, and the ULPs were trained on how to prepare medication for unplanned times away along with medication training upon hire. CNS/LALD-D stated they did not have documentation for the training. On January 28, 2026, at 12:12 p.m., ULP-B stated they were trained on how to prepare medication for unplanned times away upon hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660			

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0 660	Continued From page 13 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a complete tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. 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: The TB risk assessment dated December 23, 2025, was incomplete and lacked an updated TB risk assessment. The facility TB risk assessment lacked a designated and documented qualified person or team with primary responsibility for the	0 660			

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0 660	Continued From page 14 TB infection control program. The TB risk assessment did not indicate whether the facility was at a low, medium, or high risk for TB transmission. On January 28, 2026, at 10:41 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the facility TB risk assessment was not completed due to an oversight. The licensee's Infection Control 8.16 Tuberculosis Screening Policy indicated the facility will identify an individual staff member responsible for the TB program. The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. 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;	0 680			

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0 680	Continued From page 15 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license. 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 EPP last updated March 24, 2024, lacked evidence of the following required content: - quarterly review of missing residents policy; - yearly review of the EPP; - EPP program patient population;	0 680			

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0 680	Continued From page 16 - policies and procedures for medical documents; and - roles under a waiver declared by secretary. On September 4, 2025, at 2:36 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the missing resident plan and the EPP was reviewed once a year, but they did not have documentation for the review. CNS/LALD-D also stated they were not aware of the requirement to include the above-mentioned topics in the EPP policy. The licensee's 2.28 Missing Resident policy dated July 1, 2024, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented. The licensee's 9.01 Emergency Preparedness Plan - Appendix-Z Compliance dated July 1, 2021, indicated emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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:	0 775			

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0 775	Continued From page 17 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 January 20, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 790 SS=F	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	0 790			

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0 790	Continued From page 18 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 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 20, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 19 (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 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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0 810	Continued From page 20	0 810			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810			

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0 810	Continued From page 21 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 January 20, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;	01330			

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NAME OF PROVIDER OR SUPPLIER TRANQUIL LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2521 WILSHIRE BOULEVARD MOUND, MN 55364		
(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
01330	Continued From page 22 (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training was completed in all required areas for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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 the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. ULP-B ULP-B was hired on January 1, 2020, to provide direct care services to residents. On January 27, 2026, at 8:35 a.m., the surveyor	01330			

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01330	Continued From page 23 observed ULP-B perform medication administration to R2. ULP-E ULP-E was hired on June 10, 2023, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-E administered evening and nighttime medications to R2. ULP-F ULP-F was hired on March 18, 2024, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-F administered morning medications to R2. ULP-B, ULP-E, and ULP-F's employee training record lacked evidence to demonstrate the ULPs had received the following competency evaluations: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the residents. On January 28, 2026, at approximately 12:00 p.m., CNS/LALD-D stated they were not aware they were missing the above-mentioned training for the above-mentioned employees. The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated the evaluation for unlicensed personnel providing assisted living services must include: a. observing, reporting, and documenting resident status;	01330			

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01330	Continued From page 24 b. basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; c. reading and recording temperature, pulse, and respirations of the resident; d. recognizing physical, emotional, cognitive, and developmental needs of the resident; e. safe transfer techniques and ambulation; f. range of motioning and positioning; and g. administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470			

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01470	Continued From page 25 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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 entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. ULP-B ULP-B was hired on January 1, 2020, to provide direct care services to residents. On January 27, 2026, at 8:35 a.m., the surveyor observed ULP-B perform medication administration to R2. ULP-E ULP-E was hired on June 10, 2023, to provide direct care services to residents.	01470			

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01470	Continued From page 27 R2's Medication Administration Record indicated ULP-E administered evening and nighttime medications to R2. ULP-F ULP-F was hired on March 18, 2024, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-F administered morning medications to R2. ULP-B, ULP-E, and ULP-F's employee training record lacked evidence to demonstrate the ULPs had received an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. On January 28, 2026, at 11:41 a.m., CNS/LALD-D stated they did give verbal training to employees on the licensee's policy and procedures manual upon hire and when there was a change, but they did not have documentation to demonstrate the training was completed. Although requested, the licensee did not provide a policy or procedure pertaining to contents of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500			

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01500	Continued From page 28 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500			

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01500	Continued From page 29 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on obsevation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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 the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar	01500			

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01500	Continued From page 30 with current minimum assisted living requirements. ULP-B ULP-B was hired on January 1, 2020, to provide direct care services to residents. On January 27, 2026, at 8:35 a.m., the surveyor observed ULP-B perform medication administration to R2. ULP-E ULP-E was hired on June 10, 2023, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-E administered evening and nighttime medications to R2. ULP-F ULP-F was hired on March 18, 2024, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-F administered morning medications to R2. ULP-B, ULP-E, and ULP-F's employee record lacked evidence to demonstrate they received annual training on the following required topics: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of provider's policies and procedures. On January 28, 2026, at 11:41 a.m., CNS/LALD-D stated they were not aware of the requirement to train employees annually on the above-mentioned topics. CNS/LALD-D stated	01500			

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01500	Continued From page 31 they did give verbal training to employees on the providers policy and procedure manual upon hire and when there was a change, but not annually. CNS/LALD-D stated they did not have documentation for the policies and procedures training that was given upon hire. The licensee's 5.06 Annual Required Staff Training dated January 1, 2022, read, "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person."	01500			

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01500	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500			
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 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	01530			

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01530	Continued From page 33 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 observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP-B, ULP-E, ULP-F) received at least two hours of dementia care training every year and two hours of initial training on mental illness and de-escalation topics within 160 hours of start date. 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 entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements.	01530			

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01530	Continued From page 34 ULP-B ULP-B was hired on January 1, 2020, to provide direct care services to residents. On January 27, 2026, at 8:35 a.m., the surveyor observed ULP-B perform medication administration to R2. ULP-B's employee record included a total of 1.5 hours of dementia training completed between the two dates of July 19, 2023, and August 17, 2023. ULP-B's employee record lacked 0.5 hours of dementia training for 2023, to meet the required two hours of annual dementia training. ULP-B's employee record lacked evidence to demonstrate ULP-B had received any of the required two hours of annual dementia training for year 2024 and 2025. ULP-B's employee record also included 6.75 hours of dementia training completed on January 26, 2026, during the survey. ULP-E ULP-E was hired on June 10, 2023, to provide direct care services to residents. R2's Medication Administration Record indicated ULP-E administered evening and nighttime medications to R2. ULP-E's employee record included dementia training last completed on August 30, 2023. ULP-E's employee record lacked evidence to demonstrate ULP-E had received any of the required two hours of annual dementia training for year 2024 and 2025. ULP-F ULP-F was hired on March 18, 2024, to provide direct care services to residents.	01530			

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01530	Continued From page 35 R2's Medication Administration Record indicated ULP-F administered morning medications to R2. ULP-B, ULP-E, and ULP-F's employee record lacked evidence to demonstrate the ULPs had received any of the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date. On January 28, 2026, at 11:20 p.m., CNS/LALD-D stated since the licensee's facility was not a dementia care facility, their understanding of dementia training was that employees were supposed to be trained once upon hire on dementia care. CNS/LALD-D stated they were not aware of the required training on mental illness, and all the above-mentioned employees had worked at the licensee's facility for more than 160 hours. The licensee's 3.01 ALDC Additional Dementia Staff Training policy dated July 1, 2021, read, "POLICY: It is the policy of Tranquil Living that staff who work with residents with Alzheimer's disease and other dementias have proper training for the tasks assigned. PROCEDURE: 1. Preservice and in-service trainings will be conducted using various training methods, as determined by the trainer. These may include classroom style, web-based, video, one-on-one training, etc. 2. Training will be documented and will indicate staff knowledge and understanding of such training. 3. Persons conducting such training will be qualified to train in the care of individuals with dementia. Qualification will include the following:	01530			

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01530	Continued From page 36 a. Two years or work experience related to Alzheimer's disease or other dementias, or in other health care, gerontology, or another related field, and; b. Has completed and passed training approved by MDH. 4. The Licensed Assisted Living Director (LALD) will complete at least ten hours of annual continuing education training related to the care of individuals with dementia. These ten hours of training are included in the Director's annual required hours of training. Training must include medical management of dementia, creating and maintaining supportive and therapeutic environments for residents with dementia, and transitioning and coordinating services for residents with dementia. 5. Staff Training. a. Staff will be trained to provide a person-centered care approach. b. All direct care staff assigned to provide care for residents with dementia will be trained to work with residents with Alzheimer's disease and other dementias. c. Staff training will include the following topics: i. Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and ii. Standards of dementia care, including nonpharmacological dementia care practices that are person-centered, and evidence informed. 6. The facility will conduct retraining of staff when it is determined a staff person is not demonstrating competency when performing assigned tasks. If retraining does not result in competency, the facility will identify additional steps it will follow to ensure the staff person achieves competency, the time frame for completing the additional steps, and the actions the facility will take to protect resident's rights	01530			

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01530	Continued From page 37 (when applicable) until competency is achieved." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, for one of one resident (R2).	01610			

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01610	Continued From page 38 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. R2 was admitted to the licensee on July 24, 2024, with diagnoses that included multiple sclerosis, anxiety disorder, ataxia, depression, insomnia, and spinal stenosis. R2's Service Plan signed and dated December 1, 2025, indicated R2 received services for bathing, dressing, grooming, continence care, medication administration, meal assistance, and mental health management. On January 27, 2026, at 5:35 p.m., via email, CNS/LALD-D provided two 90-day assessments for R2 which appeared to be completed on Residex (electronic medical record software) on the following dates: - July 23, 2024; electronically signed by LALD/CNS on 7/23/24 at 7:11 p.m.; and - July 23, 2025; electronically signed by LALD/CNS on 7/23/25 at 7:11 p.m.	01610			

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01610	Continued From page 39 On January 28, 2026, at approximately 12:15 p.m., CNS/LALD-D stated they did not have an admission or 14-day assessment for R2 and stated it was an oversight. On January 28, 2026, at 12:50 p.m., CNS/LALD-D stated their understanding of the required nursing assessment completion timeline was to complete nursing assessments once a year for each resident. The surveyor then inquired to see resident assessment reports (history of previously completed assessments) on Residex. CNS/LALD-D signed into Residex and the surveyor observed the following information as CNS/LALD-D navigated through the Residex system: R2's assessment history indicated the following: <table><tr><td>Assessment Type</td><td>Assessment Date</td><td>Assessment Completed By</td></tr><tr><td>Admission</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Admission</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Dietary Preferences</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Leisure Activity Inventory</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Individual Review</td><td>1/27/26</td><td>CNS/LALD</td></tr></table> R2's Residex assessment history did not include the assessments mentioned above for the completion dates of July 23, 2024, and July 23, 2025. On January 29, 2026, at 1:18 p.m., CNS/LALD-D stated they did the admission assessment when they did a facility tour with R2, but they did not have record of it. CNS/LALD-D stated, "I meet them for the tour and that is when I assess". On January 28, 2026, at 1:30 p.m., the surveyor	Assessment Type	Assessment Date	Assessment Completed By	Admission	1/26/26	CNS/LALD	Admission	1/26/26	CNS/LALD	Dietary Preferences	1/26/26	CNS/LALD	Leisure Activity Inventory	1/26/26	CNS/LALD	Individual Review	1/27/26	CNS/LALD	01610			
Assessment Type	Assessment Date	Assessment Completed By																					
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Admission	1/26/26	CNS/LALD																					
Dietary Preferences	1/26/26	CNS/LALD																					
Leisure Activity Inventory	1/26/26	CNS/LALD																					
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01610	Continued From page 40 asked CNS/LALD-D where the provided assessments originated from since they were not included on the resident's assessment history list. CNS/LALD-D stated, "I copy and paste them, I copied it from the most recent one." CNS/LALD-D stated for R2, they copied and pasted information from the January 26, 2026, assessment (conducted during the survey) and back dated it. The surveyor asked CNS/LALD-D if they understood that doing so was falsification of documentation. CNS/LALD-D stated, "Now that you explain it; yes". CNS/LALD-D stated they did not have any other assessments on paper other than the documents they had already provided to the surveyor, and the same was true for all residents. R2 had one nursing assessment completed (during the survey) for the entire time of their stay at the licensee's facility. R2 did not have an admission assessment, 14-day assessment, or 90-day assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	01620			

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01620	Continued From page 41 executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620			

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01620	Continued From page 42 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 26, 2026, at 11:25 a.m., via telephone, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee was familiar with current minimum assisted living requirements. R1 R1 was admitted to the licensee on December 23, 2018, with diagnoses that included nontraumatic subarachnoid, acquired absence of right great toe, respiratory failure with hypoxia hypertension, and type two diabetic without complication. R1's Service Plan signed and dated July 10, 2025, indicated R1 received services for bathing,	01620			

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01620	Continued From page 43 dressing, grooming, continence care, medication administration, meal assistance, and mental health management. R2 R2 was admitted to the licensee on July 24, 2024, with diagnoses that included multiple sclerosis, anxiety disorder, ataxia, depression, insomnia, and spinal stenosis. R2's Service Plan signed and dated December 1, 2025, indicated R2 received services for bathing, dressing, grooming, continence care, medication administration, meal assistance, and mental health management. R3 R3 was admitted to the licensee on November 3, 2022, with diagnoses that included flaccid hemiplegia, foot drop, hypertension, and nontraumatic subdural hemorrhage. R3's Service Plan signed and dated November 3, 2025, indicated R3 received services for bathing, dressing, grooming, continence care, transfer, assistance with medication self-administration, meal assistance, and mental health management. R4 R4 was admitted to the licensee on October 15, 2018, with diagnoses that included schizoaffective disorder, bipolar, anxiety disorder, hypertension, hypothyroidism, obesity, and type two diabetic without complication. R4's Service Plan signed and dated June 2, 2025, indicated R4 received services for bathing, dressing, grooming, assistance medication self-administration, medication set up, meal	01620			

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01620	Continued From page 44 assistance, and mental health management. On January 27, 2026, at 7:21a.m., via email, the surveyor requested a copy of R1's record including R1's initial nursing assessment, 14-day assessment, and the three most recent 90-day assessments from the licensee. On January 27, 2026, at 1:11 p.m., the surveyor sent another email to CNS/LALD-D to provide R1's documents requested at 7:21 a.m. At 1:27 p.m., CNS/LALD-D provided partial documents. At 2:26 p.m., via email, the surveyor requested R2's assessments and highlighted the missing documents from R1's record and requested CNS/LALD-D to provide the documents by 4:30 p.m. At 5:34 p.m., and 5:35 p.m., CNS/LALD-D provided more records for R1 and R2 via email. The email sent by the licensee to the surveyor on January 27, 2026, at 1:27 p.m., contained three 90-day assessments for R1 which appeared to be completed on Residex (electronic medical record software) on the following dates: - June 10, 2025; electronically signed by LALD/CNS on 6/10/25 at 5:17 p.m. - September 10, 2025; electronically signed by LALD/CNS on 9/10/25 at 10:17 p.m.; and - December 10, 2025; electronically signed by LALD/CNS on 12/10/25 at 10:17 p.m. The email sent by the licensee to the surveyor on January 27, 2026, at 5:35 p.m., contained three 90-day assessments for R2 which appeared to be completed on Residex on the following dates: - July 23, 2024; electronically signed by LALD/CNS on 07/23/24 at 7:11 p.m.; and - July 23, 2025; electronically signed by LALD/CNS on 07/23/25 at 7:11 p.m.	01620			

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01620	Continued From page 45 On January 28, 2026, at approximately 12:15 p.m., CNS/LALD-D stated they did not have an admission or 14-day assessment for R2 and stated it was an oversight. The surveyor then requested R3's assessments. CNS/LALD-D stated the assessments for R3 were at their house. The surveyor asked CNS/LALD-D to print the documents directly from Residex and email them to the surveyor. CNS/LALD-D stated they did not use Residex. The surveyor showed the trademark "© 2025 TenX Systems, LLC dba Residex" on the bottom pages of R1's assessments to CNS/LALD-D and questioned why the trademark was there if they did not use Residex to do the assessments. CNS/LALD-D stated, they sometimes used Residex to complete assessments. The surveyor asked CNS/LALD-D what other method they had used to complete resident assessments. CNS-LALD-D did not answer the surveyor's questions, but directed one of the licensee's unlicensed personnel (ULP) to their home to gather assessments and stated their house was five minutes away. A few minutes later, the surveyor observed and overheard CNS/LALD-D speaking on the phone and directing the person on the other end of the line of places to look for assessments. The licensee did not produce any additional paper assessments. On January 28, 2026, at 12:39 p.m., CNS/LALD-D stated they missed doing R3's assessments. CNS/LALD-D stated they were cited for not having R3's admission assessment following a previous survey (concluded on March 21, 2024), they completed only one assessment for R3 in year 2024, and "I completely overlooked, and he only has one assessment." On January 28, 2026, at 12:50 p.m.,	01620			

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01620	Continued From page 46 CNS/LALD-D stated their understanding of the required nursing assessment completion timeline was to complete nursing assessments once a year for each resident. The surveyor then inquired to see resident assessment reports (history of previously completed assessments) on Residex. CNS/LALD-D signed into Residex and the surveyor observed the following information as CNS/LALD-D navigated through the Residex system: R1's assessment history indicated the following: <table><tr><td>Assessment Type</td><td>Assessment Date</td></tr><tr><td>Assessment Completed By</td><td></td></tr><tr><td>Individual Review</td><td>9/15/23</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Admission</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Dietary Preferences</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Resident Bio / History</td><td>4/18/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Individual Review</td><td>4/19/24</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Admission</td><td>1/26/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Dietary Preferences</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>MAHC 10 (Fall Risk)</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr><tr><td>Individual Review</td><td>1/27/26</td></tr><tr><td>CNS/LALD-D</td><td></td></tr></table> R1's Residex assessment history did not include R1's assessments mentioned above and provided by CNS/LALD-D for the completion	Assessment Type	Assessment Date	Assessment Completed By		Individual Review	9/15/23	CNS/LALD-D		Admission	4/18/24	CNS/LALD-D		Dietary Preferences	4/18/24	CNS/LALD-D		Leisure Activity Inventory	4/18/24	CNS/LALD-D		Leisure Activity Inventory	4/18/24	CNS/LALD-D		Resident Bio / History	4/18/24	CNS/LALD-D		Individual Review	4/19/24	CNS/LALD-D		Admission	1/26/26	CNS/LALD-D		Dietary Preferences	1/27/26	CNS/LALD-D		Leisure Activity Inventory	1/27/26	CNS/LALD-D		MAHC 10 (Fall Risk)	1/27/26	CNS/LALD-D		Individual Review	1/27/26	CNS/LALD-D		01620			
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01620	Continued From page 47 dates of June 10, 2025; September 10, 2025; and December 10, 2025. R2's assessment history indicated the following: <table><tr><td>Assessment Type</td><td colspan="2">Assessment Date</td></tr><tr><td>Assessment Completed By</td><td colspan="2"></td></tr><tr><td>Admission</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Admission</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Dietary Preferences</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Leisure Activity Inventory</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Individual Review</td><td>1/27/26</td><td>CNS/LALD</td></tr></table> R2's Residex assessment history did not include R2's assessments mentioned above and provided by CNS/LALD-D for the completion dates of July 23, 2024, and July 23, 2025. R2 had one nursing assessment completed (during the survey) for the entire time of their stay at the licensee's facility. R2 did not have an admission assessment, 14-day assessment, or 90-day assessments. On January 28, 2026, at approximately 12:40 p.m., CNS/LALD-S provided the surveyor with an assessment for R3 with the Residex trademark, dated March 21, 2024. R3's assessment history indicated the following: <table><tr><td>Assessment Type</td><td colspan="2">Assessment Date</td></tr><tr><td>Assessment Completed By</td><td colspan="2"></td></tr><tr><td>Pre-Admission</td><td>4/15/24</td><td>CNS/LALD</td></tr><tr><td>Admission</td><td>4/16/24</td><td>CNS/LALD</td></tr><tr><td>Resident Bio / History</td><td>4/16/24</td><td>CNS/LALD</td></tr><tr><td>Dietary Preferences</td><td>4/16/24</td><td>CNS/LALD</td></tr><tr><td>Leisure Activity Inventory</td><td>4/16/24</td><td>CNS/LALD</td></tr><tr><td>Individual Review</td><td>4/16/24</td><td>CNS/LALD</td></tr></table>	Assessment Type	Assessment Date		Assessment Completed By			Admission	1/26/26	CNS/LALD	Admission	1/26/26	CNS/LALD	Dietary Preferences	1/26/26	CNS/LALD	Leisure Activity Inventory	1/26/26	CNS/LALD	Individual Review	1/27/26	CNS/LALD	Assessment Type	Assessment Date		Assessment Completed By			Pre-Admission	4/15/24	CNS/LALD	Admission	4/16/24	CNS/LALD	Resident Bio / History	4/16/24	CNS/LALD	Dietary Preferences	4/16/24	CNS/LALD	Leisure Activity Inventory	4/16/24	CNS/LALD	Individual Review	4/16/24	CNS/LALD	01620			
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01620	Continued From page 48 Dietary Preferences 4/19/24 CNS/LALD R3's Residex assessment history did not include R3's assessment provided by the CNS/LALD-D dated March 21, 2024. On January 28, 2026, at 12:39 p.m., CNS/LALD-D stated they were cited for R3's admission assessment on the previous survey conducted on March 21, 2024, and they completed R3's admission assessment in 2024. CNS/LALD-D stated they completely overlooked R3's assessments and did not do additional assessments after the assessments completed in April 2024. R4 <table><tr><td>Assessment Type</td><td>Assessment Date</td><td></td></tr><tr><td>Assessment Completed By</td><td></td><td></td></tr><tr><td>Individual Review</td><td>9/15/23</td><td>CNS/LALD</td></tr><tr><td>Admission</td><td>4/19/24</td><td>CNS/LALD</td></tr><tr><td>Dietary Preferences</td><td>4/19/24</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>4/19/24</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>Resident Bio / History</td><td>4/19/24</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>Individual Review</td><td>4/19/24</td><td>CNS/LALD</td></tr><tr><td>Individual Review</td><td>1/26/26</td><td>CNS/LALD</td></tr><tr><td>Resident Bio / History</td><td>1/26/26</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>Dietary Preferences</td><td>1/26/26</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>Leisure Activity Inventory</td><td>1/26/26</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr><tr><td>MAHC 10 (Fall Risk)</td><td>1/26/26</td><td></td></tr><tr><td>CNS/LALD</td><td></td><td></td></tr></table> R4 had one nursing assessment completed for	Assessment Type	Assessment Date		Assessment Completed By			Individual Review	9/15/23	CNS/LALD	Admission	4/19/24	CNS/LALD	Dietary Preferences	4/19/24		CNS/LALD			Leisure Activity Inventory	4/19/24		CNS/LALD			Resident Bio / History	4/19/24		CNS/LALD			Individual Review	4/19/24	CNS/LALD	Individual Review	1/26/26	CNS/LALD	Resident Bio / History	1/26/26		CNS/LALD			Dietary Preferences	1/26/26		CNS/LALD			Leisure Activity Inventory	1/26/26		CNS/LALD			MAHC 10 (Fall Risk)	1/26/26		CNS/LALD			01620			
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01620	Continued From page 49 the entire time of their stay at the licensee's facility. On January 28, 2026, at 12:50 p.m., CNS/LALD-D stated their understanding of the required nursing assessment completion timeline was to complete nursing assessments once a year for each resident. CNS/LALD-D stated they were not aware of the 90-day nursing assessment requirement. On January 28, 2026, at 1:14 p.m., CNS/LALD-D stated R4 was admitted in year 2018 and back then they used paper assessments and completed the assessments once a year. CNS/LALD-D further stated they started using Residex after the last survey and completed assessments once a year and R4's last assessment was completed in April of 2024. The surveyor asked if they were following their belief that assessments were due annually, why they did not complete another survey in April of 2025 for R4. CNS/LALD-D stated, "It was overlooked in 2025". On January 28, 2026, at 1:30 p.m., the surveyor asked CNS/LALD-D if the assessments mentioned above were not included in the assessment histories, where did they come from. CNS/LALD-D stated, "I copy and paste them, I copied it from the most recent one." CNS/LALD-D stated they copied and pasted from January 26, 2026, assessment for R2 and back dated it. Surveyor asked CNS/LALD-D if they understood that this was falsification of documentation. CNS/LALD-D stated, "Now that you explain it; yes". CNS/LALD-D stated they did not have any other assessments on paper other than the Residex document they already provided to the surveyor and this was true for all residents.	01620			

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01620	Continued From page 50 On January 29, 2026, at 11:50 a.m., CNS/LALD-D stated they signed up with Residex in year 2023. CNS/LALD-D stated they received Residex training once and it was too complicated. On January 29, 2026, at approximately 12:00 p.m., the surveyor asked if CNS/LALD-D had received the citation report from the previous survey. CNS/LALD-D stated yes, they had received it. The surveyor read the following report from the previous survey and asked CNS/LALD-D how they were still not aware of the 90-day nursing assessment requirement, LALD/CNS-C stated they were not aware of the 90-day assessment requirement and the content requirements per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. CNS/LALD-D stated, "like I said, it was an oversight." On January 29, 2026, at 1:20 p.m., CNS/LALD-D stated the three-assessments mentioned above as copy pasted from the most recent assessments for R1's 90-day assessment were made up to be three months apart because the surveyor's email for copy of resident document requested 90-day nursing assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760			

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01760	Continued From page 51 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record (MAR) and medication was administered as prescribed for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on July 24, 2024, with diagnoses that included multiple sclerosis, anxiety disorder, ataxia, depression, insomnia, and spinal stenosis. R2's Service Plan signed and dated December 1,	01760			

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01760	Continued From page 52 2025, indicated R2 received services for bathing, dressing, grooming, continence care, medication administration, meal assistance, and mental health management. R2's signed physician order dated December 4, 2025, indicated an order for Clonazepam 0.5 milligrams (mg) every day. R2's physician order did not indicate an order for vitamin D3. R2's MAR for the month of January 2026, indicated an order for vitamin D3 400 unit, give one tablet by mouth once daily and clonazepam 0.5mg one tablet by mouth once daily for sleep. The clonazepam was scheduled for 8:00 a.m. The MAR indicated clonazepam 0.5 mg was administered at 8:00 a.m., on the following dates: - January 5, and January 6, 2026; and - January 17, through January 20, 2026. The MAR indicated vitamin D3 was administered on the following dates: - January 6, 2026; and - January 17, through January 20, 2026. The MAR indicated both vitamin D and clonazepam were not given for the rest of the days of January 2026. On January 27, 2026, at 8:35 a.m., the surveyor observed medication administration performed by unlicensed personnel (ULP)-B. ULP-B documented vitamin D3 as not given and stated R2 did not have Vitamin-D3 supply. ULP-B also documented clonazepam as not given and stated clonazepam was given at night for sleep but the time on the MAR was not changed to reflect the correct time. The surveyor then observed R2's medication supply and noted that both vitamin D3 and clonazepam were not included in R2's medication supply. ULP-B stated they were not	01760			

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01760	Continued From page 53 aware that R2 did not have supply for clonazepam, they only worked mornings, and they did not know much about evening medications. On January 28, 2026, at 1:45 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they were not aware that R2 was not getting Vitamin D3 and clonazepam. CNS/LALD-D stated they did do medication review every month and it was an oversight. CNS/LALD-D stated they had emailed the pharmacy to clarify the orders. On January 28, 2026, at 2:04 p.m., via email, CNS/LALD-D forwarded an email they received from the licensee's preferred pharmacy on January 28, 2026, at 2:01 p.m., in response to the inquiry they sent on January 28, 2026, at 1:44 p.m., asking why R2's vitamin D3 was not in the medication pack. The email from pharmacy read, "We have not sent this since 07/06/2025. It looks like it may have been related to a coverage issue. The script also expired on 12/04/2025. I ran a test claim, and the insurance plan will cover it if a new script is sent in." On January 28, 2026, at 5:10 p.m., CNS/LALD-D forwarded to the surveyor an email they received from the licensee's preferred pharmacy on January 28, 2026, at 5:00 p.m., in response to an inquiry they sent on January 28, 2026, at 4:40 p.m., asking why R2's clonazepam was not refilled. The email from pharmacy read, "We got a new order on it 11/10/2025 and sent a 30-day supply. [Licensee's name] is our only facility that narcotics go into cycle, and the pharmacist missed adding the cycle fill indicator on the medication when we got the new order in November causing it not to pull into the	01760			

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01760	Continued From page 54 December cycle fill." On January 29, 2026, at 10:54 a.m., ULP-B stated they had informed CNS/LALD-D over the phone the first day they noticed R2 did not have the above listed medication. On January 29, 2026, at 11:02 a.m., CNS/LALD-D stated they were not informed about the above-mentioned missing medication and the wrong administration time for clonazepam up until this survey. R2's record included two signed Medication Administration Review Records dated October 10, 2025, and January 9, 2026; the signature was illegible with no printed name to identify the reviewer. Both reviews indicated all current medications were listed correctly in the medication administration record, based on current prescription label, or prescriber's current written or electronic order. Both reviews also indicated there were no medication administration errors discovered during the review; and there was no pattern of medication administration errors identified. On January 29, 2026, at 12:19 p.m., the surveyor requested CNS/LALD-D explain the licensee's protocol for completing the medication review mentioned above. CNS/LALD-D stated they come into the facility to do the medication review and stated that they check the medication pack against the physician order and the MAR. CNS/LALD-D stated they did not catch the errors for R2's clonazepam and vitamin D3. The licensee's 7.22 Medication and Treatment Records- Documentation & Refusal policy dated January 1, 2022, indicated the licensee will create	01760			

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01760	Continued From page 55 and maintain a correct and accurate medication and/or treatment/ therapy record for each resident receiving medication assistance or administration and treatments and therapies. If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			



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

TRANQUIL LIVING
2521 Wilshire Boulevard
Mound, MN 55364
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34050

Risk:
License:
Expires on:
CFPM: CAROL FILLMORE
CFPM #: FM12492; Exp: 03/08/2028

Inspection Info

Report Number: F8087261019
Inspection Type: Full - Single
Date: 1/27/2026 Time: 11:00:00 AM
Duration: minutes
Announced Inspection: No
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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT

FLOORS: HARDWOOD - NON COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: SAMSUNG

DISHWASHER: MAYTAG

STOVE/RANGE: GE

HAND WASHING SINK: YES - SINGLE BIN PORCELAIN KITCHEN SINK

NON COMPLIANT COUNTERTOP, FLOOR, AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PROBE USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087261019 from 1/27/2026

John Boettcher

BILL BAYE
HOUSE MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@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

TRANQUIL LIVING
Mound
County/Group: Hennepin County

Inspection Info

Report Number: F8087261019
Inspection Type: Full
Date: 1/27/2026
Time: 11:00:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment: SAMSUNG

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment: SAMSUNG

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment: SAMSUNG

Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT LEAFY GREENS; Temperature Process: Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment: SAMSUNG

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at 10 Degrees F.

Comment: SAMSUNG

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 38 Degrees F.

Comment: HOT POINT

Violation Issued?: No

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

Location: Upright Cooler at 38 Degrees F.

Comment: HOT POINT

Violation Issued?: No

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

Location: Upright Cooler at 38 Degrees F.

Comment: HOT POINT

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at 0 Degrees F.

Comment: HOT POINT

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34050016	Date: 1/26/2026
Facility Name: Tranquil Living	
Facility Address: 2521 Wilshire Boulevard, Mound, MN 55364	

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

Comments:

The egress door from resident room 3 leading out to the rear porch was obstructed and did not readily open when attempted. The egress door must be maintained free of obstruction.

The rear patio did not have a clear egress path to the public right of way. Accumulated snow was built up in the pathways

3. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Extension cords were in use in the living room near the fireplace. These extension cords were removed during the survey. Extension cords should not be used in lieu of permanent wiring.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The extinguishers provided throughout the facility were purchased on October 24, 2025 according to attached receipts. No records of monthly staff inspections were provided for extinguishers and staff confirmed that monthly checks had not occurred. The provided extinguishers in the kitchen and basement hallway also had packaging elements attached to them including a cardboard tube on the handles and plastic tag that would prevent the pin from being removed readily. The extinguishers should be maintained in proper working order, free of packaging that might obstruct their use. Extinguishers should receive monthly staff inspections that are recorded.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; 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 closet door in resident room 1 was off of its tracks and would not open properly when tested.

An outlet in the living room was missing the protective cover. The protective cover should be replaced on the outlet.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: No documentation of resident actions for evacuation was provided to the surveyor.

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

Comments: No unique resident needs for evacuation were provided to the surveyor.

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: No records of staff trainings on the FSEP were provided to the surveyor during the survey. ULP-A stated that required documentation would be emailed to the surveyor. No further documentation was provided.

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: No records of resident trainings on the FSEP were provided to the surveyor during the survey. ULP-A stated that required documentation would be emailed to the surveyor. No further documentation was provided.