



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 10, 2026

Licensee

West Saint Paul Opco LLC
315 Thompson Avenue East
West Saint Paul, MN 55118

RE: Project Number(s) SL30684016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,500.00**. 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:

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

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with West Saint Paul Opco LLC. **Please contact Jodi Johnson at 507-344-2730 on or before April 15, 2026, to schedule the conference call.**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30684	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER WEST SAINT PAUL OPCO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118		
(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: SL30684016-0 On March 9, 2026, through March 12, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issued on March 9, 2026, at a level 3/Widespread (I). The license took immediate action; however, the scope and level remain at I. 1960: An immediate correction order was issued on March 11, 2026, at a level 3/Isolated (G). The licensee took immediate action; however, the scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 2310: An immediate correction order was issued on March 11, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 2320: An immediate correction order was issued on March 11, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	0 000			
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 110			

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0 110	Continued From page 2 The findings include: On March 9, 2026, at 10:09 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website identified there was no active Director of Record for the facility. During the entrance conference on March 10, 2026, registered nurse (RN)-Q stated LALD-A worked for the management company and was the LALD for the facility. On March 11, 2026, at 1:11 p.m., BELTSS representative indicated LALD-Q added herself as the Director of Record on March 9, 2026 (after the survey had begun). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be	0 430			

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0 430	Continued From page 3 completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) as required. This had the potential to affect all 10 residents living in the facility. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: On March 9, 2026, at 2:08 p.m., owner (O)-F stated a change of ownership was effective on January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated after a change of ownership, the residents should have a new contract which would include the UDALSA. RN-Q further stated the licensee had been working on the contracts, but not all of them were completed. R1 began receiving services under the assisted living with dementia care (ALFDC) license on	0 430			

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0 430	Continued From page 4 January 15, 2026. R2 began receiving services under the ALFDC license on January 15, 2026. R1 and R2's records lacked evidence of being provided with the UDALSA. On March 11, 2026, at 11:58 a.m., RN-Q stated R1 and R2 do not hava a signed contract which would have included the UDALSA. The licensee's 3.06 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated December 1, 2025 indicated the licensee must provide prospective residents with a Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form that is approved by the Minnesota Department of Health (MDH) prior to signing an Assisted Living Contract. This form must be accurate and reflect the current license and scope of services offered. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430			
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 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	0 470			

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0 470	Continued From page 5 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470			

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0 470	Continued From page 6 The licensee's census was 10 residents, all of whom received services under the assisted living with dementia care license. During the facility tour on March 9, 2026, at 12:36 a.m. with registered nurse (RN)-B, no posting for staffing was observed. RN-B stated there was a staff schedule above the medication cart. The surveyor noted the posted schedule was not the current week, rather it was the prior week's schedule. When asked by the surveyor at this time, RN-B stated the residents would not be able to see the staff schedule from their wheelchair due to the small print, and there was not another staff posting that could be seen by the residents or their visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;	0 480			

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0 480	Continued From page 7 (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480			

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0 480	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency	0 500			

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0 500	Continued From page 9 evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials	0 500			

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0 500	Continued From page 10 who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 10, 2026, at 11:37 a.m., registered nurse (RN)-Q stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Assisted Living Change of Ownership (CHOW) Application License, section titled Official Verification of Owner or Authorized Agent, (page 13 and 14 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.	0 500			

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0 500	Continued From page 11 - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.	0 500			

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0 500	Continued From page 12 - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 14 was electronically signed by the authorized agent on July 30, 2025. The licensee had an assisted living license issued on January 15, 2026, with an expiration date of January 14, 2027.	0 500			

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0 500	Continued From page 13 The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0510, 0550, 1290, 1440, 1460, 1500, 1540, 1620, 1640, 1700, 1750, 1760, 1790, 1880, 1890, 1900, 1940, 1960, 2240, 2310, 2320, and 2410, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	0 500			

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0 500	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during medication administration by one of two unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 510			

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0 510	Continued From page 15 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 9, 2026, during continuous observation by the surveyor, observed the following: - 1:12 p.m. ULP-G was setting setting up medications for R1. ULP-G punched acetaminophen out of the medication card, and a pill fell on the floor. ULP-G picked up the pill with her ungloved hand, placed it into the medication cup, and administered the medications to R1. ULP-G did not was hands or use hand sanitizer. - 1:18 p.m. ULP-G was setting setting up medications for R5. ULP-G punched acetaminophen out of the medication card, and a pill fell onto the medications cart. ULP-G picked up the pill with her ungloved hand, placed it into the medication cup and administered the medication to R5. - 1:27 p.m. ULP-G was setting setting up medications for R2. ULP-G punched acetaminophen out of the medication card, and a pill fell onto the medications cart. ULP-G picked up the pill with her ungloved hand, placed it in the medication cup, and went to the kitchen to obtain thickened water. ULP-G administered the oral medications to R2, used hand sanitizer, put on gloves, administered eye drops, and removed the gloves. ULP-G did not wash hands or use hand sanitizer and began setting up medications for the next resident. On March 10, 2026, at 10:41 a.m. registered nurse (RN)-Q stated staff should wash hands or use sanitizer between residents when passing medications. If staff drop a pill, staff should wear	0 510			

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0 510	Continued From page 16 gloves when touching the medication, they should dispose of it in the proper container and punch a new pill out of the card. The licensee provided page 6-7 of an unidentified policy, the pages provided were undated. The document included: "Hand Hygiene: Staff must perform hand hygiene using soap and water or alcohol-based hand rubs: - Before and after resident contact. - After contact with potentially contaminated surfaces or objects. - After removing gloves or PPE [personal protective equipment]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	0 550			

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0 550	Continued From page 17 Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post, in a conspicuous place, the facility's grievance procedure. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 12:36 p.m. during the facility tour with registered nurse (RN)-B, the surveyor observed a box by the office with a document on the box which read "We want to hear from you! Have a menu suggestion? comment? complaint? Please feel free to leave other comments on how we can serve you better. Your feedback is greatly appreciated". The document did not include the required information about the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Nor did it have the required contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities or information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The	0 550			

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0 550	Continued From page 18 notice did not include the required the required statement, if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. On March 9, 2026, at 12:36 p.m., RN-B stated there was no posting regarding the facility's grievance procedure and she was unaware it needed to be posted. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=D	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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	0 650			

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0 650	Continued From page 19 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 the required content for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 10, 2026, beginning at 7:15 a.m., the surveyor observed ULP-C administering medications to the licensee's residents. ULP-C was hired on June 10, 2024, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On March 12, 2026, at 9:30 a.m., registered nurse (RN)-B stated ULP-C's employee record	0 650			

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0 650	Continued From page 20 lacked the required content as noted above. RN-B further indicated ULP-C should have had a performance review in 2025. The licensee's undated Associate Personnel Checklist included: - performance appraisals. The licensee's employee record and annual performance policies were requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

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0 680	Continued From page 21 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 have a written emergency preparedness plan (EPP) with the required content. In addition, the licensee failed to post the emergency preparedness plan (EPP). 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) 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: EPP CONTENT The licensee's Emergency Preparedness Plan Manual was dated as effective December 1, 2025. The emergency plan did not include: - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP; and - emergency officials contact information including Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, and Office of Ombudsman On March 12, 2026, at 2:48 p.m., registered	0 680			

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0 680	Continued From page 22 nurse (RN)-Q stated the above noted items were not included in the licensee's EPP. POSTING OF EP PLAN On March 9, 2026, at 12:36 p.m. during the facility tour with RN-B, the surveyor did not observe the EPP posted or a notice indicating where the EPP was located. On March 12, 2027, at 2:47 p.m., RN-B stated the EPP binder was located in a closet in the hallway. RN-B was unaware the EPP needed to be posted. The licensee's Emergency Preparedness policy and procedure overview dated December 1, 2025, indicated the emergency preparedness objectives were to comply with law, fulfill requirements of Minnesota Assisted Living licensure and CMS (Centers for Medicare & Medicaid Services) Emergency Preparedness Rule. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	0 690			

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0 690	Continued From page 23 Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's service documentation dated March 2026, included initials and N/A (not applicable) in the boxes to indicate if services were delivered and a second page included initials, signature, and title. The service documentation included the initials for two ULPs which were not identified on the second page. R1's Med (Medication) Sheets dated March 2026, included initials in the boxes to indicate medications had been administered by employees. A signature page included initials, signature, and title. The Med (Medication) Sheets included the initials for two ULPs which were not identified on the signature page. R2 R2's service documentation dated March 2026, included initials and N/A in the boxes to indicate if services were delivered and a second page included initials, signature, and title. The service	0 690			

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0 690	Continued From page 24 documentation included the initials for two ULPs which were not identified on the second page. R2's Med (Medication) Sheets dated March 2026, included initials in the boxes to indicate medications had been administered by employees. A signature page included initials, signature, and title. The Med (Medication) Sheets included the initials for one ULP which was not identified on the signature page. On March 11, 2026, at 9:53 a.m., RN-B stated staff should have documented their name, title, initials on the bottom of the sheet or the back sheet. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure written records.	0 700			

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0 700	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 9, 2026, at 11:57 a.m., the surveyor observed unlicensed personnel (ULP)-G setting up medications at a medication cart in a common area of the facility and utilized a paper medication administration record (MAR) sitting on the cart. ULP-G set up medications for R4, locked them in the medication cart, and left the area to ask the resident to come and take her medications. The MAR was left open and visible to any staff, residents, or visitors. R4 wanted her medications in her room, so ULP-G retrieved the medications from the medication cart and went to R4's room to administer her medications, again leaving the MAR open to R4's personal information which included name, medications, diagnoses, and date of birth. On March 9, 2026, at 1:27 p.m., ULP-G set up medications for R2, went to the kitchen to obtain thickened liquids and left the MAR open and visible to any staff, residents, or visitors. R2's MAR included personal information of name, medications, diagnoses, and date of birth. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated staff should close or cover the MAR when they walk away to protect private	0 700			

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0 700	Continued From page 26 information. The licensee's 1.17 Resident Record -Access, Storage, and Confidentiality policy dated December 1, 2025, indicated resident records shall be kept confidential and secured in an area where only authorized Community Staff have access. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730			

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0 730	Continued From page 27 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document services provided as identified on the service plan for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 730			

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0 730	Continued From page 28 The findings include: On March 10, 2026, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R1 in his room. Additionally, the surveyor observed a hooyer lift in R1's room. ULP-C stated the hooyer lift was used for all of R1's transfers. R1's Personal Service Plan signed June 9, 2025, indicated R1 received hooyer lift assist with all transfers. R1's service documentation dated March 2026, included initials and N/A (not applicable) in the boxes to indicate if services were delivered. All evening services lacked documentation and were blank March 1, 3, 4, 6, 7, 8, 2026. Additionally, R1's service documentation did not include the service of hooyer lift transfers. R2 R2's service documentation dated March 2026, included initials and N/A (not applicable) in the boxes to indicate if services were delivered. All evening services lacked documentation and were blank March 1, 3, 4, 6, 7, 8, 2026. On March 11, 2026, at 9:53 a.m., RN-B stated documenting services and signing off on the services had been a problem with all the staff and they had a meeting to discuss and retrain on it. On March 12, 2026, at 2:47 p.m., registered nurse (RN)-Q stated R1's record should have included documentation of hooyer lift transfers. No further information was provided.	0 730			

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0 730	Continued From page 29	0 730			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical 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 3/9/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			

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0 810	Continued From page 30	0 810			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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 31 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/9/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must:	0 900			

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0 900	Continued From page 32 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a signed contract for four of four residents (R1, R2, R6, R7) prior to providing assisted living services as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 900			

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0 900	Continued From page 33 On March 9, 2026, at 2:08 p.m., owner (O)-F stated a change of ownership was effective on January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated after change of ownership the residents should have a new contract. RN-Q further stated the licensee had been working on the contracts, but not all of them were completed. R1 On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering medications to R1. R1 began receiving services from the licensee on January 15, 2026. On March 11, 2026, at 11:58 a.m., RN-Q stated R1 did not have a signed contract. R2 On March 9, 2026, at 1:27 p.m., the surveyor observed ULP-G administering medications to R2. R2 began receiving services from the licensee on January 15, 2026. R2's contract was signed by R2's responsible party on March 9, 2026 (after the survey was initiated). R6 On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to R6. R6 began receiving services from the licensee on	0 900			

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0 900	Continued From page 34 January 15, 2026. R7 On March 10, 2026, at 7:25 a.m., the surveyor observed ULP-C administering medications to R7. R7 began receiving services from the licensee on January 15, 2026. On March 12, 2026, at 12:01 p.m., RN-Q stated R6 and R7 did not have a signed contract. The licensee's Execution of the Assisted Living Contract dated December 1, 2025, indicated a fully executed Assisted Living Contract must be signed by the resident (or their representative) and received by the community prior to occupancy or initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith	01290			

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01290	Continued From page 35 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP)-C, ULP-D, and ULP-E). This resulted in an immediate correction order on March 9, 2026. In addition, the licensee failed to ensure ten of ten employees (ULP-G, ULP-H, ULP-I, ULP-J, ULP-K, ULP-N, ULP-O, dining coordinator (DC)-L, resident engagement manager (REM)-M, licensed practical nurse (LPN)-P) had a background study affiliation with this provider's Health Facility Identification (HFID) number 30684. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on June 10, 2024, and provided	01290			

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01290	Continued From page 36 unsupervised direct care services for the licensee's residents. The licensee's staff schedule dated February 22, 2026, through March 7, 2026, indicated ULP-C worked on February 22, 24, 25, 26, 27, 2026, and March 2, 3, 4, 5, 7, 2026. The licensee's staff schedule dated March 8, 2026, through March 21, 2026, indicated ULP-C worked on March 8, 2026. The licensee's NETStudy 2.0 roster did not include ULP-C. There was no current background study in NETStudy 2.0 for ULP-C. ULP-D ULP-D was hired January 13, 2025, and provided unsupervised direct care services for the licensee's residents. The licensee's staff schedule dated February 22, 2026, through March 7, 2026, indicated ULP-D worked on March 2, 2026. The licensee's NETStudy 2.0 roster did not include ULP-D. There was no current background study in NETStudy 2.0 for ULP-D. ULP-E ULP-E was hired August 26, 2004, and provided unsupervised direct care services for the licensee's residents. ULP-E's time sheet records indicated ULP-E worked February 8, 9, 10, 11, 12, 13, 14, and 15,	01290			

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01290	Continued From page 37 2026. The licensee's NETStudy 2.0 roster did not include ULP-E. There was no current background study in NETStudy 2.0 for ULP-E. ULP-G ULP-G was hired May 6, 2025, and provided unsupervised direct care services for the licensee's residents. On March 9, 2026, beginning at 11:57 a.m., the surveyor observed ULP-G administering medications to the licensee's residents. ULP-H ULP-H was hired June 13, 2025, and provided unsupervised direct care services for the licensee's residents. ULP-I ULP-I was hired July 1, 2025, and provided unsupervised direct care services for the licensee's residents. ULP-J ULP-J was hired January 13, 2025, and provided unsupervised direct care services for the licensee's residents. ULP-K ULP-K was hired April 21, 2025, and provided unsupervised direct care services for the licensee's residents. ULP-N ULP-N was hired August 18, 2025, and provided unsupervised direct care services for the	01290			

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01290	Continued From page 38 licensee's residents. ULP-O ULP-O was hired February 19, 2025, and provided unsupervised direct care services for the licensee's residents. DC-L DC-L was hired April 3, 2025, and had unsupervised contact with the licensee's residents. REM-M REM-M worked intermittently at the facility and had unsupervised contact with the licensee's residents. LPN-P LPN-P was hired June 12, 2025, and provided unsupervised direct care services for the licensee's residents. ULP-G, ULP-H, ULP-I, ULP-J, ULP-K, ULP-N, ULP-O, DC-L, REM-M, and LPN-P was not included in the facility's NETStudy roster for the licensee's HFID 30684. NETStudy 2.0 indicated ULP-G, ULP-H, ULP-I, ULP-J, ULP-K, ULP-N, ULP-O, DC-L, REM-M, and LPN-P were affiliated with the licensee's sister facility HFID 30634. On March 9, 2026, at 2:50 p.m., registered nurse (RN)-B stated all of the staff listed above would have direct contact with the licensee's residents, and they should have had a background study on file. No further information provided.	01290			

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01290	Continued From page 39 TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at I.	01290			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing	01440			

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01440	Continued From page 40 or therapy tasks within 30 days of first providing those services for one of two unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on May 6, 2025, and provided delegated tasks to the licensee's residents. On March 9, 2026, at 11:57 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence a 30 day supervision of delegated tasks had been completed. On March 12, 2026, at 8:54 a.m., registered nurse (RN)-Q stated ULP-G should have had a 30-day supervision, but she was unable to find one for ULP-G. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors	01460			

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01460	Continued From page 41 (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the one	01460			

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01460	Continued From page 42 contracted agency staff (registered nurse (RN)-B) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 12:00 p.m., RN-B stated she worked for a contracted staffing agency and was the interim director of nursing for the licensee. On March 12, 2026, at 2:47 p.m., RN-Q stated human resources did not have any evidence RN-B had received orientation to the assisted living facility. The licensee's 2.05 Temporary and Contracted Staff Requirements dated December 1, 2026, indicated the licensee may use temporary or supplemental staff from a Supplemental Nursing Services Agency (SNSA) or individual contractors to meet staffing needs. All temporary and contracted staff must meet the same requirements as employed Community Staff and will be treated as agents of the Community, consistent with MN Statute 1440.60, subdivision 5. "Orientation and Training All temporary and contracted staff must be oriented by the Clinical Nurse Supervisor (DON)	01460			

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01460	Continued From page 43 or designee prior to providing care. Orientation must include: - The individual needs of each assigned resident. - The resident's current service plan. - The Community's policies and methods of documentation. - Other elements required to provide safe and effective assisted living services. The licensee's 2.06 Employee General Orientation and Required Content dated December 1, 2025, indicated all staff and supervisors of [licensee] who are providing and/or supervising direct services must complete a comprehensive orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training 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	01500			

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01500	Continued From page 44 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 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,	01500			

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01500	Continued From page 45 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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to the liecnsee's residents. ULP-C was hired on June 10, 2024, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documented evidence of the following required annual training: - 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; and - Principles of person-centered planning and	01500			

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01500	Continued From page 46 service delivery and how they apply to direct support services provided by the staff person. On March 12, 2026, at 9:30 a.m., registered nurse (RN)-B stated ULP-C's employee file lacked the required annual training as noted above. The licensee's 2.14 Annual Required Staff Training policy dated December 1, 2025, noted the following elements MUST be included every 12 months for all staff who perform direct services: 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. 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 two	01540			

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01540	Continued From page 47 hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-G) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an Assisted Living Facility with Dementia Care license.	01540			

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01540	Continued From page 48 ULP-C On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to the facility's residents. ULP-C was hired on June 10, 2024, to provide direct care and services to the licensee's residents. ULP-C's employee record contained evidence the employee received four hours and 30 minutes (4.5 hours) of dementia care training, not the required eight (8) hours of training within 80 working hours of the employment start date. In addition, ULP-C's record contained evidence the employee received 30 minutes (.5) of mental illness and de-escalation training, not the required two hours of training with 80 working hours. In addition, ULP-C's employee record lacked evidence the employee received two hours of dementia care training and one hour of mental illness and de-escalation training annually as required. On March 12, 2026, at 9:30 a.m., registered nurse (RN)-B reviewed ULP-C's employee record and stated ULP-C had not completed the required training as noted above. ULP-G ULP-G was hired on May 6, 2025, and provided delegated tasks to the facility's residents. On March 9, 2026, at 11:57 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's employee record contained evidence the employee received four hours and 30 minutes	01540			

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01540	Continued From page 49 (4.5 hours) of dementia care training, not the required eight (8) hours of training within 80 working hours of the employment start date. On March 12, 2026, at 2:47 p.m., RN-Q stated staff should have had all the required dementia training and if it was not on the employee's training transcript then it had not been competed. The licensee's 2.13 Dementia Care, Mental Illness, and De-escalation Training Requirements policy dated December 1, 2025, indicated all staff were required to complete dementia training at the time of hire and annually thereafter. Direct care staff dementia requirement: - Eight hours of initial training within 80 hours of first day of employment and two hours of training on topics related to dementia care for each 12 months of employment thereafter. Direct care staff mental illness & de-escalation requirement: - Two hours of initial training within 80 working hours of first day of employment and one hour of training for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
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	01620			

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01620	Continued From page 50 physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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	01620			

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01620	Continued From page 51 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day assessment as required for five of five residents (R1, R2, R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a change of ownership effective January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated when the change of ownership occurred, the licensee retained the service plans and physician orders. All other resident documents would be started as of January 15, 2026. R1 On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering medications to R1.	01620			

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01620	Continued From page 52 R1 began receiving services from the licensee on January 15, 2026. R1's Admission Assessment was dated February 9, 2026. As of March 12, 2026, R1's record lacked evidence a 14-day assessment had been completed and it had been 31 days since the admission assessment. R2 On March 9, 2026, at 1:27 p.m., the surveyor observed ULP-G administering medications to R2. R2 began receiving services from the licensee on January 15, 2026. R2's Admission Assessment was dated February 25, 2026. As of March 12, 2026, R2's record lacked evidence a 14-day assessment had been completed and it had been 15 days since the admission assessment. R5 On March 9, 2026, at 1:18 p.m., the surveyor observed ULP-G administering medications to R5. R5 began receiving services from the licensee on January 15, 2026. R5's Admission Assessment was dated February 17, 2026. As of March 12, 2026, R5's record lacked evidence a 14-day assessment had been	01620			

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01620	Continued From page 53 completed and it had been 23 days since the admission assessment. R6 On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to R6. R6 began receiving services from the licensee on January 15, 2026. R6's Admission Assessment was dated February 20, 2026. As of March 12, 2026, R5's record lacked evidence a 14-day assessment had been completed and it had been 20 days since the admission assessment. R7 On March 10, 2026, at 7:25 a.m., the surveyor observed ULP-C administering medications to R7. R7 began receiving services from the licensee on January 15, 2026. R7's Admission Assessment was dated February 18, 2026. As of March 12, 2026, R7's record lacked evidence a 14-day assessment had been completed and it had been 22 days since the admission assessment. On March 12, 2026, at 9:24 a.m., RN-B stated she was working on admission assessments for the licensee and a sister facility. All admission assessments for this licensee were completed, but none of the residents had 14-day	01620			

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01620	Continued From page 54 assessments. The licensee's 4.01 Assessments, Reviews, & Monitoring policy dated December 1, 2025, included: A. Initial Nursing Assessment (Pre-Admission) 1. Timing: The initial nursing assessment must be completed prior to contract execution or move-in, whichever occurs first. C. Ongoing Assessment and Monitoring (Full Service Plan) 1. Initial Post-Admission Reassessment: Resident reassessment and monitoring will be conducted no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640			

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01640	Continued From page 55 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement all services included in the service plan for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering Humulin NPH insulin (intermediate acting) to R1. ULP-G stated R1 "sleeps in sometimes, so I give it with the noon meal." ULP-G signed off the insulin as administered at 8:00 a.m. ULP-G further stated R1 did not have blood sugar checks. R1 was admitted under the previous owners on June 9, 2025, with diagnoses including dementia, diabetes, fracture of T11-T12, reduced mobility, weakness, and anxiety. The licensee's change of	01640			

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01640	Continued From page 56 ownership began on January 15, 2026, and R1 began receiving assisted living services from the new owners on January 15, 2026. R1's physician orders dated May 27, 2025, indicated R1 was to receive blood glucose checks twice daily. R1's Personal Service Plan signed June 9, 2025, indicated because R1 had a diagnosis of diabetes the following were in place: - Be alert to signs of high or low blood sugar: Note that either can present with fatigue, headache, and/or loss of consciousness. High may also display: skin warm and dry, pulse weak and rapid, respiration rapid, blurred vision, vomiting, fruity odor to breath, excessive urination, dry mouth/intense thirst or difficulty concentrating; Low may also display: skin cold and clammy, pulse full and bounding, sweating, shaking, hunger, slurred speech, dizziness, confusion or anxiety. - Perform blood sugar monitoring three or more times per week including equipment calibration and record results. - Perform insulin injections and rotate injection sites. R1's Assessment Summary dated June 9, 2025, indicated the licensee would perform the following services for a certain rate: - Resident has been diagnosed with Diabetes. - Specific care and/or monitoring because of the chronic condition(s) noted above. - Resident has insulin-dependent diabetes. - Supervise or perform blood sugar monitoring three or more times per week. - Administer insulin injections. R1's Hospice IDG (inter-disciplinary group)	01640			

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01640	Continued From page 57 Comprehensive Assessment and Plan of Care Update Report dated February 11, 2026, included the following: - "Appropriate blood glucose levels will be maintained to prevent a hyper/hypoglycemic event." - "assess/obtain blood glucose levels per physician orders" - Check blood sugar twice a day and as needed. R1's medication administration record (MAR) dated March 2026, did not include blood glucose monitoring, and R1's record lacked evidence the blood glucose checks had been discontinued. R1's Admission Assessment (completed due to new ownership) dated March 2, 2026, indicated R1 had a diagnosis of diabetes and received Metformin (oral diabetes medication) and Humulin insulin. R1's assessment did not indicate R1 received blood glucose monitoring. On March 11, 2026, at 10:32 a.m., registered nurse (RN)-B stated R1 does not receive blood glucose monitoring. The licensee's 4.04 Service Plan Development and Requirements policy dated January 2026, indicated the Community will implement and provide all services indicated in the final, agreed-upon service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services	01700			

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01700	Continued From page 58 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for two of two residents (R1, R2) who received medication management services. This practice resulted in a level two violation (a	01700			

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01700	Continued From page 59 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 had a change of ownership effective January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated when the change of ownership occurred, the licensee retained the service plans and physician orders. All other resident documents would be started as of January 15, 2026. R1 On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering medications to R1. R1 began receiving services from the licensee on January 15, 2026. R1's Admission Assessment was dated February 9, 2026. The assessment did not include a review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R2 On March 9, 2026, at 1:27 p.m., the surveyor observed ULP-G administering medications to R2.	01700			

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01700	Continued From page 60 R2 began receiving services from the licensee on January 15, 2026. R2's Admission Assessment was dated February 25, 2026. The assessment did not include a review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On March 12, 2026, at 9:24 a.m., registered nurse (RN)-B stated she was unaware the assessment needed to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. The licensee's 5.01 Medication Management-Assessment, Monitoring and Reassessment policy dated December 1, 2025, included: 2. Medication Identification: The assessment must include an identification and review of all medications the resident is known to be taking, including prescriptions, over-the-counter medications, and supplements. 3. Clinical Review: The review must include documentation of: - Indications for all medications. - Side effects, contraindications, and known allergic or adverse reactions. - Actions to address these potential issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750			

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01750	Continued From page 61 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of one unlicensed personnel (ULP)-C with documenting medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 10, 2026, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-C set up oral medications for R6 in a medication cup and documented as administered before actually administering medications to R6.	01750			

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01750	Continued From page 62 On March 10, 2026, at 7:25 a.m., the surveyor observed ULP-C set up oral medications for R7 in a medication cup and documented as administered before actually administering medications to R7. On March 10, 2026, at 7:38 a.m., the surveyor observed ULP-C set up oral medications for R2 in a medication cup, removed eye drops and a topical gel, and documented as administered before actually administering medications to R2. On March 10, 2026, at 8:00 a.m., the surveyor observed ULP-C set up oral medications for R2 in a medication cup, and topical medications, and documented as administered before actually administering medications to R2. On March 10, 2026, at 8:25 a.m., the surveyor observed ULP-C set up oral medications for R3 in a medication cup, and documented as administered before actually administering medications to R3. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-B stated staff had not been signing off the medications; therefore, she had trained the staff to sign off the medications on their last check prior to administering medications. The licensee provided Medication Administration Agenda for a meeting held on February 25, 2026, indicated the following: - 1. "As many of you are aware there have been many medications errors in the last few weeks/months. This cannot happen. We are responsible for providing medications to a vulnerable population that cannot manage their medications independently. We MUST	01750			

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01750	Continued From page 63 administer their medications as ordered by their doctor. This meeting is to make sure you very clearly understand what the procedure is and what is expected of you during your medication passes." - 2. "Starting immediately, we will be starting to hold staff accountable when medication errors are made" - "if you do not sign off in the MAR, then the medication was not given. Period! Medications are SO VERY IMPORTANT." - 3. "Procedure with Expectations when passing the medication. a. Wash your hands b. Open the MAR to the Resident in which you are going to pass meds (medications) to. c. Pull out the medication cards. c. Read the 1st medication order Complete the 6 Rights of Medication Administration - Right Resident - Right Medication - Right Date - Right Time - Right Dose - Right Route" d. Complete this 3 times to ensure you do not make medication errors. - When you pull out the card - Before you punch the card, - When you are signing off in the MAR, prior to giving the medication to the resident. [although the policy instructs to document administration after the medication is administered] 4. New Documentation Required: Initial and date on the medication card next to the bubble you popped the medication out of This is for ALL medications not just narcotics. Initial in the MAR	01750			

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01750	Continued From page 64 5. Administer the medication per MD order." The licensee's undated, 2.04 Oral Medication Administration Competency included: "6. Before, during, and after medication administration, check the six rights of medication administration by confirming against the MAR/resident chart: Right Resident Right Medication Right Date Right Time Right Route Right Dose" "10. Encourage resident to take medication with full glass of water" "12. Document the administration on the MAR" "13. If the medication is a PRN (as needed) administration, document the effectiveness of the medication within 60 minutes of administration 14. Appropriately document any refusals on the MAR, and report to the nurse, as appropriate" The licensee's 5.16 Medication and Treatment Record - Documentation and Refusal Policy dated January 15, 2026, indicated the following: - Required Documentation: The following elements must be documented in the resident's medication and/or treatment/therapy records (MAR/TAR) after providing assistance or administration: - The date - The time - The quantity of dosage - The method of administration of all prescribed and over-the-counter medications and/or treatments/therapy - Documentation on the MAR/TAR of the authorized person (initials/signature) who provided the assistance and/or administration.	01750			

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01750	Continued From page 65 - Documentation of Errors and Omissions 1. Non-Completion: If medication and/or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must immediately include: - The reason why it was not completed (e.g., resident refusal, held due to vital signs, medication unavailable). - Any follow-up procedures that were provided (e.g., RN notified, vital signs retaken). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one of	01760			

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01760	Continued From page 66 two residents (R1), failed to accurately document medication administration, failed to document administration of medications, and failed to document follow up for as needed medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Failed to administer medications as ordered On March 9, 2026, at 1:12 p.m., the surveyor observed unlicensed personnel (ULP)-G setting up R1's medications for administration. ULP-G punched acetaminophen 325 mg two tablets into the medication cup and administered the medication to R1. R1's prescription label indicated acetaminophen 325 mg take three tablets by mouth three times a day. R1's physician orders dated June 9, 2026, included acetaminophen 325 mg three tablets by mouth three times a day. R1's medication administration record (MAR) dated March 2026, included acetaminophen 325 mg three tablets by mouth three times a day. Although the surveyor observed two tablets being administered, ULP-G had signed off that three tablets were administered on March 9, 2026, at 2:00 p.m.	01760			

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NAME OF PROVIDER OR SUPPLIER WEST SAINT PAUL OPCO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118		
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01760	Continued From page 67 On March 11, 2026, at 9:53 a.m., registered nurse (RN)-B stated staff should have administered three tablets as ordered. RN-B reviewed the medication card and confirmed only two tablets had been punched out. Failed to accurately document medication administration On March 9, 2026, at 12:06 p.m., the surveyor observed ULP-G administering Humulin NPH insulin (intermediate acting) to R1. ULP-G stated R1 "sleeps in sometimes, so I give it with the noon meal." ULP-G signed off the insulin as administered at 8:00 a.m. R1's physician orders dated May 27, 2025, included: - Humulin NPH insulin inject 12 units subcutaneously every morning and inject 4 units subcutaneously every evening. On March 11, 2026, at 9:53 a.m., registered nurse (RN)-B stated if staff were to administer a medication at a different time, staff should have circled their initials and documented when it was administered and the reason it was not administered at the time it was ordered on the back of the sheet. Failed to document medications and failed to document effectiveness of as needed medications: R1 R1's MAR dated February 1-28, 2026, identified the following:	01760			

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01760	Continued From page 68 - aspirin 81 mg by mouth every day at 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026; - Insulin NPH inject 12 units every morning at 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 2-15, 18, 28, 2026; - Insulin NPH inject 4 units every evening 6:00 p.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 19, 21, 22, 27, 28, 2026; - lidoderm patch apply to lower back every morning 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026; - lidoderm patch remove every evening at 8:00 p.m. There were no initials in the box to indicate whether the patch was removed for February 2-15, 18, 21, 22, 24-28, 2026; - losartan (heart) 25 mg by mouth every day 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026; - venlafaxine (antidepressant) 150 mg by mouth every day 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026; - divalproex (seizure/mood) 125 mg 3 capsules by mouth twice a day 8:00 a.m. and 8:00 p.m.; at 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 2-15, 18, 21, 22, 27, 28, 2026; - gabapentin (seizures) 100 mg 2 capsules by mouth twice a day 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February	01760			

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01760	Continued From page 69 3-15, 18, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 2-15, 18, 21, 22, 27, 28, 2026; - metformin (diabetes) 1000 mg by mouth twice a day at 10:00 a.m. and 1:00 p.m. At 10:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026. At 1:00 p.m., there were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026; - nystatin powder (yeast infection) apply topically to groin twice a day 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 1-15, 21, 22, 26-28, 2026; - sennosides (constipation) 8.6 mg by mouth twice a day 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 1-15, 21, 22, 27, 28, 2026; - acetaminophen 325 mg give 3 tablets three times a day at 8:00 a.m., 2:00 p.m., 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 28, 2026. At 2:00 p.m., there were no initials in the box to indicate whether it was administered for February 3-15, 18, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 1-16, 21, 22, 27, 28, 2026. In addition, hydromorphone (narcotic pain medication) 2 mg give 1/2 tablet every 2 hours as needed for pain was administered February 22 for a pain level of "8," on February 25 for a pain	01760			

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01760	Continued From page 70 level of "10," and February 26, for a pain level of "10." The MAR lacked documentation of effectiveness of the medication. R1's MAR dated March 1-11, 2026, identified the following: - lidocaine 4% (numbing/pain) patch on lower back remove at bedtime after approximately 12 hours after it was applied. On March 2, 2026, at 8:00 p.m., there was no initials in the box to indicate whether this was completed; and - Humulin NPH insulin inject 4 units one time per day in the evening. On March 7, 2026, and March 8, 2026, at 6:00 p.m., there were no initials in the box to indicate whether this was administered. R2 R2's MAR dated February 1-28, 2026, identified the following: - furosemide 20 mg by mouth every day at 8:00 a.m. There were no initials in the box to indicate whether it was administered for February 3-15, 28 2026; - mirabegron (urinary incontinence) 25 mg by mouth every evening at 6:00 p.m. There were no initials in the box to indicated whether it was administered for February 2-15, 17, 18, 20-22, 27, 28, 2026; - Protonix 40 mg by mouth twice a day at 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 19, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 2-15, 19, 21, 27, 28, 2026; - Systane eye drops twice a day at 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in	01760			

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01760	Continued From page 71 the box to indicate whether it was administered for February 3-15, 19, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 1-15, 19, 21, 27, 28, 2026; - diclofenac gel apply 4 grams to right hip twice a day at 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 19, 28 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 2-15, 21, 22, 27, 28, 2026; - acetaminophen 500 mg give 1000 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for February 3-15, 28, 2026. At 2:00 p.m., there were no initials in the box to indicate whether it was administered for February 3-15, 28, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for February 2-15, 18, 21, 22, 27, 28, 2026. In addition, although the acetaminophen was documented as not available at 8:00 a.m. and 2:00 p.m. on February 17 and 18, it was documented as administered 8:00 p.m. on February 17. R2's March 2026, MAR dated March 1-11, 2026, identified the following: - mirabegron (urinary incontinence) 25 mg by mouth every evening at 6:00 p.m., there were no initials in the box to indicate whether it was administered for March 1, 2, 9, 2026; - Protonix 40 mg by mouth twice a day at 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for March 1, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for March 1, 2, 6, 8,	01760			

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01760	Continued From page 72 2026; - Systane eye drops three times a day. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for March 2, 6, 8, 2026; - diclofenac gel apply 4 grams to right hip twice a day 8:00 a.m. and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for March 5, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for March 1, 2, 8, 10, 2026; - acetaminophen 500 mg give 1000 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. At 8:00 a.m., there were no initials in the box to indicate whether it was administered for March 5, 2026. At 2:00 p.m., there were no initials in the box to indicate whether it was administered for March 5, 2026. At 8:00 p.m., there were no initials in the box to indicate whether it was administered for March 2, 2026. On March 11, 2026, at 9:53 a.m., registered nurse (RN)-B reviewed March's MARs with the surveyor. RN-B stated staff should have signed off on the MARs when administering medications. Additionally, RN-B and the surveyor observed the medication cards which many punched out medications did not have initials beside them. RN-B stated staff were also instructed to sign off on the medications cards. On March 12, 2026, at 10:15 a.m., RN-B stated the licensee did not have any medication errors, only documentation errors, and it looked as if the medications were given, but not documented. There were no medication error reports since the licensee changed ownership on January 15, 2026.	01760			

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01760	Continued From page 73 The licensee provided Medication Administration Agenda for a meeting held on February 25, 2026, indicated the following: - 1. "As many of you are aware there have been many medications errors in the last few weeks/months. This cannot happen. We are responsible for providing medications to a vulnerable population that cannot manage their medications independently. We MUST administer their medications as ordered by their doctor. This meeting is to make sure you very clearly understand what the procedure is and what is expected of you during your medication passes." - 2. "Starting immediately, we will be starting to hold staff accountable when medication errors are made" - "if you do not sign off in the MAR, then the medication was not given. Period! Medications are SO VERY IMPORTANT." - 3. "Procedure with Expectations when passing the medication. a. Wash your hands b. Open the MAR to the Resident in which you are going to pass meds (medications) to. c. Pull out the medication cards. c. Read the 1st medication order Complete the 6 Rights of Medication Administration - Right Resident - Right Medication - Right Date - Right Time - Right Dose - Right Route" d. Complete this 3 times to ensure you do not make medication errors. - When you pull out the card - Before you punch the card, - When you are signing off in the MAR,	01760			

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01760	Continued From page 74 prior to giving the medication to the resident. [although the policy instructs to document administration after the medication is administered] 4. New Documentation Required: Initial and date on the medication card next to the bubble you popped the medication out of This is for ALL medications not just narcotics. Initial in the MAR 5. Administer the medication per MD order." The licensee's undated, 2.04 Oral Medication Administration Competency included: "6. Before, during, and after medication administration, check the six rights of medication administration by confirming against the MAR/resident chart: Right Resident Right Medication Right Date Right Time Right Route Right Dose" "10. Encourage resident to take medication with full glass of water" "12. Document the administration on the MAR" "13. If the medication is a PRN (as needed) administration, document the effectiveness of the medication within 60 minutes of administration 14. Appropriately document any refusals on the MAR, and report to the nurse, as appropriate" The licensee's 5.16 Medication and Treatment Record - Documentation and Refusal Policy dated January 15, 2026, indicated the following: - Required Documentation: The following elements must be documented in the resident's medication and/or treatment/therapy records (MAR/TAR) after providing assistance or administration:	01760			

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01760	Continued From page 75 - The date - The time - The quantity of dosage - The method of administration of all prescribed and over-the-counter medications and/or treatments/therapy - Documentation on the MAR/TAR of the authorized person (initials/signature) who provided the assistance and/or administration. - Documentation of Errors and Omissions 1. Non-Completion: If medication and/or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must immediately include: - The reason why it was not completed (e.g., resident refusal, held due to vital signs, medication unavailable). - Any follow-up procedures that were provided (e.g., RN notified, vital signs retaken). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790			

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01790	Continued From page 76 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was	01790			

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01790	Continued From page 77 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of two employees (unlicensed personnel (ULP)-G) providing medications for residents with unplanned time away from home when the licensed nurse was not available. 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 included: ULP-G ULP-G was hired on May 6, 2025, and provided delegated tasks to the licensee's residents. On March 9, 2026, at 11:57 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence ULP-G had	01790			

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01790	Continued From page 78 been trained and competency tested for providing medications to residents with unplanned time away. On March 12, 2026, at 2:47 p.m., registered nurse (RN)-Q stated ULP-G should have been trained and competency tested for providing medications to residents for unplanned time away. The licensee's undated, 2.27 Unplanned Time Away Medication Set-Up policy indicated For unplanned time away, medication set up can be delegated to unlicensed personnel, and cannot be for more than seven days at a time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored per manufacturer guidelines. 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	01880			

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NAME OF PROVIDER OR SUPPLIER WEST SAINT PAUL OPCO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118		
(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
01880	Continued From page 79 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 9, 2026, at 2:02 p.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-G and included the following: - R6 had an unopened bottle of latanoprost eye drops in the box that was stored in the medication cart at room temperature; and - R8 had an unopened bottle of latanoprost eye drops in the box that was stored in the medication cart at room temperature. On March 9, 2026, at 2:00 p.m., ULP-G stated she was unaware unopened latanoprost needed to be stored in the refrigerator. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-B stated unopened latanoprost should have been stored in the refrigerator. The licensee's 5.08 Medication Storage and Security policy dated January 15, 2026, indicated medications would be stored per manufacturer guidelines. Latanoprost prescribing information dated August 2011, included "store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01890	Continued From page 80	01890			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with the date opened for the licensee's three residents (R1, R6, R8) with time sensitive medications and failed to ensure medications were maintained bearing the original prescription label. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering Humulin N to R1. The insulin pen did not contain an open date. On March 9, 2026, at 2:02 p.m., the surveyor	01890			

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01890	Continued From page 81 observed the medication cart with ULP-G and noted the following: - R6 had an opened and in use bottle of latanoprost eye drops without an open date; - R8 had an opened and in use bottle of latanoprost eye drops without an open date; and - 2 tablets in foil packaging with loperamide 2 milligrams (mg) on the package were in the medication cart, not in a box and no pharmacy label. On March 9, 2026, at 2:02 p.m., ULP-G stated she was unaware insulin and latanoprost required an open date and were time sensitive after opening them. ULP-G took the loperamide and stated it must belong to R2 and began putting it in a box labeled with a prescription label for her. The surveyor noted in the same drawer was a box of loperamide for R8. When questioned, ULP-G stated she was unsure who it belonged to, and she would give it to the nurse. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated staff should have labeled R1's Humulin N insulin with a date when it was opened, and it is only good for 14 days after opening. On March 10, 2026, at 10:41 a.m., RN-B stated open and in use bottles of latanoprost should be labeled with an open date, and all medications should be stored with a pharmacy label. The licensee's 5.08 Medication Storage and Security policy dated January 15, 2026, indicated medications would be stored per manufacturer guidelines. The licensee's 5.10 Prescription Drugs, Labeling and Private Supply policy dated December 1,	01890			

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01890	Continued From page 82 2025, indicated when the facility receives a prescription drug that staff will manage, the drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy. This container must bear the original prescription label with legible information, including the expiration or beyond-use date of a time-dated drug. Latanoprost prescribing information dated August 2011, included "Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." Humulin N prescribing information dated June 2022, included "Throw away the HUMULIN N Pen you are using after 14 days, even if it still has insulin left in it." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription insulin pens were not being saved for use by anyone other than the resident prescribed the insulin. This had the potential to affect one of one residents receiving insulin.	01900			

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01900	Continued From page 83 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 4, 2026, at 10:41 a.m., the surveyor observed the facility's medication refrigerator with unlicensed personnel (ULP)-C and registered nurse (RN)-B. The refrigerator included was a Novolog insulin pen. ULP-C stated the pen was for use with the residents if they needed it. The insulin pen had a question mark written in black marker. Attached to the pen was "Emergency Novolog Insulin Flexpen". RN-B stated she had been working for the licensee since February 2026, and further stated she was unsure who the pen belonged to, or if it was a stock supply. There was currently only one resident who received insulin and they did not use Novolog. On March 12, 2026, at 2:47 p.m., RN-B stated she had contacted the pharmacy and there was no order for stock supply and she could not figure out where the Novolog pen had come from. The licensee's 5.10 Prescription Drugs, Labeling and Private Supply policy dated December 1, 2025, included when the facility receives a prescription drug that staff will manage, the drug, prior to being set up for immediate or later administration, must be kept in the original	01900			

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01900	Continued From page 84 container in which it was dispensed by the pharmacy. This container must bear the original prescription label with legible information, including the expiration or beyond-use date of a time-dated drug. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940			

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01940	Continued From page 85 monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content 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: During the entrance conference on March 10, 2026, at 11:37 a.m. registered nurse (RN)-B stated the licensee provided treatment management services to their residents, including modified diets. On March 10, 2026, at 11:55 a.m., the surveyor observed R2 feeding herself pureed food and thickened liquids in the dining room. R2's diagnoses included mild cognitive impairment and dysphagia (difficulty swallowing). R2's Service Plan dated February 14, 2026,	01940			

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01940	Continued From page 86 indicated R2 received services including a pureed diet. R2's prescriber orders dated April 24, 2025, included an order for a pureed diet. R2's record lacked documentation of the pureed diet. R2's record lacked a treatment or therapy management plan to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On March 12, 2026, at 2:30 p.m., RN-B and RN-Q stated R2's record lacked lacked a treatment management plan to include all the required content as noted above. RN-B and RN-Q indicated they had not recognized R2's modified diet as a treatment. The licensee's 5.03 Treatment & Therapy	01940			

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01940	Continued From page 87 Management Record and Service Plan Integration dated December 1, 2025, noted residents receiving management of prescribed treatments, the facility would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: 1. A statement of the type of services that will be provided 2. Documentation of specific resident instructions relating to the treatments or therapy administration. 3. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel 4. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. 5. Any resident-specific requirements relating to documentation of treatment and therapy received. 6. Verification that all treatment and therapy was administered as prescribed. 7. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940			
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	01960			

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01960	Continued From page 88 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a prescribed treatment for one of one resident (R1). This resulted in an immediate correction order issued on March 11, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering Humulin NPH insulin (intermediate acting) to R1. ULP-G stated R1 usually gets his insulin at 8:00 a.m., but he was sleeping in this morning and therefore, she was going to administer it before he had lunch. ULP-G further stated R1 did not have blood sugar checks. R1 was admitted under previous ownership on June 9, 2025, with diagnoses including dementia, diabetes, fracture of T11-T12, reduced mobility,	01960			

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01960	Continued From page 89 weakness, and anxiety. The licensee's change of ownership began on January 15, 2026, and R1 began receiving assisted living services through the new ownership on January 15, 2026. R1's physician orders dated May 27, 2025, indicated R1 was to receive blood glucose checks twice daily. R1's Personal Service Plan signed June 9, 2025, indicated because R1 had a diagnosis of diabetes the following were in place: - Be alert to signs of high or low blood sugar: Note that either can present with fatigue, headache, and/or loss of consciousness. High may also display: skin warm and dry, pulse weak and rapid, respiration rapid, blurred vision, vomiting, fruity odor to breath, excessive urination, dry mouth/intense thirst or difficulty concentrating; Low may also display: skin cold and clammy, pulse full and bounding, sweating, shaking, hunger, slurred speech, dizziness, confusion or anxiety. - Perform blood sugar monitoring three or more times per week including equipment calibration and record results. - Perform insulin injections and rotate injection sites. R1's Assessment Summary dated June 9, 2025, indicated the licensee would perform the following services for a certain rate: - Resident has been diagnosed with Diabetes. - Specific care and/or monitoring because of the chronic condition(s) noted above. - Resident has insulin-dependent diabetes. - Supervise or perform blood sugar monitoring three or more times per week. - Administer insulin injections.	01960			

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01960	Continued From page 90 R1's Hospice IDG (inter-disciplinary group) Comprehensive Assessment and Plan of Care Update Report dated February 11, 2026, included the following: - "Appropriate blood glucose levels will be maintained to prevent a hyper/hypoglycemic event." - "assess/obtain blood glucose levels per physician orders" - Check blood sugar twice a day and as needed. R1's medication administration record (MAR) dated March 2026, did not include blood glucose monitoring, and R1's record lacked evidence the blood glucose checks had been discontinued. R1's Admission Assessment (completed due to new ownership) dated March 2, 2026, indicated R1 had a diagnosis of diabetes and received Metformin (oral diabetes medication) and Humulin insulin. R1's assessment did not indicate R1 received blood glucose monitoring. On March 11, 2026, at 10:32 a.m., registered nurse (RN)-B stated R1 does not receive blood glucose monitoring. RN-B stated she would look for an order directing to discontinue blood glucose checks. R1's hospice orders dated March 11, 2026, at 12:47 p.m., (at the time of survey and after the surveyor requested) did not include blood glucose monitoring. On March 11, 2026, at approximately 2:30 p.m., RN-Q stated staff should have followed the signed physician orders that were in R1's record. The licensee's 5.12 Medication and Treatment Orders - Implementation indicated medication	01960			

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01960	Continued From page 91 and treatment/therapy orders received must be implemented within 24 hours of receipt. The licensee's 5.03 Treatment and Therapy Management Record and Service Plan Integration policy dated December 1, 2025, indicated the treatment record must be current and documentation of administration of treatments would be recorded on the medication administration record (MAR) or designated task records. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remain at G. In addition, the licensee lacked documentation of treatments for one of two residents (R2). On March 10, 2026, at 11:55 a.m., the surveyor observed R2 feeding herself pureed food and thickened liquids in the dining room. R2's diagnoses included mild cognitive impairment and dysphagia (difficulty swallowing). R2's Service Plan dated February 14, 2026, indicated R2 received a pureed diet. R2's prescriber orders dated April 24, 2025, included an order for a pureed diet. R2's record lacked documentation of the pureed diet with thickened liquids. On March 12, 2026, at 2:15 p.m., ULP-C stated	01960			

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01960	Continued From page 92 R2 required pureed food and thickened liquids. ULP-C indicated R2 had required this diet for years due to her choking tendencies. In addition, ULP-C stated she was not required to document the modified diet was provided to R2. On March 12, 2026, at 2:30 p.m., RN-B and RN-Q stated R2's record lacked documentation of the treatment provided. RN-B and RN-Q indicated they had not recognized R2's modified diet as a treatment. No further information was provided.	01960			
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110			

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NAME OF PROVIDER OR SUPPLIER WEST SAINT PAUL OPCO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118			
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02110	Continued From page 93 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required for assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for four of four residents (R1, R2, R6, R7). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 2:08 p.m., owner (O)-F stated a change of ownership was effective on January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated after change of ownership,	02110			

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02110	Continued From page 94 the residents should have a new contract. RN-Q further stated the licensee had been working on the contracts but not all of them were completed, which would include providing the required dementia care policies. R1 On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering medications to R1. R1 began receiving services from the licensee on January 15, 2026. On March 11, 2026 at 11:58 a.m.. RN-Q stated R1 did not have a signed contract and therefore, the dementia care policies had not been provided to R1 and/or responsible party on or before admission. R2 On March 9, 2026, at 1:27 p.m., the surveyor observed ULP-G administering medications to R2. R2 began receiving services from the licensee on January 15, 2026. R2's contract was signed by R2's responsible party on March 9, 2026, after surveyor entered. Therefore, the dementia care policies had not been provided to R2 and/or responsible party on or before admission. R6 On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to R6. R6 began receiving services from the licensee on	02110			

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02110	Continued From page 95 January 15, 2026. R7 On March 10, 2026, at 7:25 a.m., the surveyor observed ULP-C administering medications to R7. R7 began receiving services from the licensee on January 15, 2026. On March 12, 2026, at 12:01 p.m., RN-Q stated R6 and R7 did not have a signed contract; therefore, they had not received the dementia care policies. The licensee's 6.01 Dementia Care Policies and Documentation Requirements dated January 15, 2026, included the dementia policies and procedures must be offered and provided to residents and the residents' legal and designated representatives at the time of Move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also	02240			

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02240	Continued From page 96 contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living	02240			

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02240	Continued From page 97 Residents was provided and a written acknowledgement was received for four of four residents (R1, R2, R6, R7) prior to providing services. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 2:08 p.m., owner (O)-F stated a change of ownership was effective on January 15, 2026. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated after change of ownership, the residents should have a new contract. RN-Q further stated the licensee had been working on the contracts but not all of them were completed, which would include the Bill of Rights. R1 On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering medications to R1. R1 began receiving services from the licensee on January 15, 2026. On March 11, 2026, at 11:58 a.m., RN-Q stated R1 did not have a signed contract. Therefore, the bill of rights had not been provided to R1 and/or responsible party on or before the licensee began providing services.	02240			

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02240	Continued From page 98 R2 On March 9, 2026, at 1:27 p.m., the surveyor observed ULP-G administering medications to R2. R2 began receiving services from the licensee on January 15, 2026. R2's contract was signed by R2's responsible party on March 9, 2026, after survey had begun. Therefore, the bill of rights had not been provided to R2 and/or responsible party on or before the licensee began providing services. R6 On March 10, 2026, at 7:15 a.m., the surveyor observed ULP-C administering medications to R6. R6 began receiving services from the licensee on January 15, 2026. R7 On March 10, 2026, at 7:25 a.m., the surveyor observed ULP-C administering medications to R7. R7 began receiving services from the licensee on January 15, 2026. On March 12, 2026, at 12:01 p.m., RN-Q stated R6 and R7 did not have a signed contract. Therefore, the bill of rights had not been provided to the resident and/or responsible party on or before the licensee began providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			

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02280 SS=C	144G.90 Subd. 5 Notice to residents; change in ownership or m (a) A facility must provide written notice to the resident, legal representative, or designated representative of a change of ownership within seven calendar days after the facility receives a new license. (b) A facility must provide prompt written notice to the resident, legal representative, or designated representative, of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the manager of the facility, if applicable; and (2) the authorized agent. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice to the residents, legal representative, or designated representative of a change of ownership within seven calendar days. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a change of ownership effective January 15, 2026. The licensee provided an email that was sent from licensed assisted living director (LALD)-A to	02280			

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02280	Continued From page 100 office staff (OS)-R on February 4, 2025, this was 20 days after the change in ownership occurred. The email was addressed to residents and family members, and included information regarding the change of ownership. The email also included there would be a resident and family night on February 10, 2026, and they were invited to attend to meet the new owners, this was 26 days after the change in ownership. On March 12, 2026, at 2:47 p.m. registered nurse (RN)-Q stated the licensee had not notified residents and resposible parties of the change of ownership within seven days, the email would have been the notification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02280			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for the licensee's one resident (R4) with a hospital bed rail and the licensee's one resident (R1) with consumer grab bars. This resulted in an immediate order issued	02310			

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02310	Continued From page 101 on March 11, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R4 On March 11, 2026, at 1:30 p.m., the surveyor observed R4 sitting in her recliner chair in her room. R4 had a hospital bed with a full length side rail on the left which was the wall side of the bed. R4 stated it helped her stay in bed. R4 further stated she did not use the side rail for repositioning. R4 was admitted on April 22, 2024, under a previous ownership. The licensee's change of ownership began on January 15, 2026, and R4 began receiving assisted living services through the new ownership on January 15, 2026. R4's diagnoses included Alzheimer's disease, anxiety, cerebrovascular disease, and muscle weakness. R4's unsigned, undated Minnesota Service Plan Contract indicated R4's services included bathing, dressing, grooming, medication and treatment management. R4's comprehensive assessment dated March 5, 2026, indicated "Full length bed rails are currently	02310			

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02310	Continued From page 102 attached to the bed but lowered and not in the up position. (R4) does not require the rails for bed mobility or transferring. Hospice bed was delivered with rails attached. Nursing to contact Hospice to have bed rails removed ASAP." The assessment did not include measurements of the side rail entrapment zones or evidence of risk versus benefits of side rail use education had been provided. R1 On March 10, 2026, at 8:06 a.m., the surveyor observed R1 lying in a hospital bed with bilateral Halo grab bars. R1 was admitted on June 9, 2025, under previous ownership. The licensee's change of ownership began on January 15, 2026, and R1 began receiving assisted living services through the new ownership on January 15, 2026. R1's diagnoses included dementia, diabetes, fracture of T11-T12, reduced mobility, weakness, and anxiety. R1's comprehensive assessment dated March 2, 2026, indicated R1 had bilateral Halo grab bars. "The bilateral grab bar have been used in the past when [R1] was able to assist In mobility from his bed. [R1] is not currently able to do that, but halo bars will stay on the bed for now." R1's assessment did not indicate if the grab bars had been installed per manufacturer guidelines or the Consumer Product Safety Commission (CSPC) had been checked for recalls. On March 11, 2026, at 12:32 p.m., registered nurse (RN)-B stated she had not checked for recalls on the CSPC and she was unsure if it had	02310			

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02310	Continued From page 103 been done previously. On March 11, 2026, at 1:40 p.m., RN-B stated R4 does not use the side rail and she had never seen it in the up position when she was working. RN-B stated she had requested hospice remove the side rail. In addition, RN-B stated R1 does not use his Halo grab bars and they would remove them from the bed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The MDH website, Assisted Living Resources & FAQs indicated licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most	02310			

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02310	Continued From page 104 up-to-date information related to portable bed side rail recall information. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remain at I.	02310			

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02320	Continued From page 105	02320			
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure one of one resident (R1) received appropriate care and services related to diabetes care and medication administration. This resulted in an immediate correction order identified on March 11, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 12:06 p.m., the surveyor observed unlicensed personnel (ULP)-G administering Humulin NPH insulin (intermediate acting) to R1. ULP-G stated R1 "sleeps in sometimes, so I give it with the noon meal." ULP-G signed off the insulin as administered at 8:00 a.m. ULP-G further stated R1 did not have	02320			

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02320	Continued From page 106 blood sugar checks. R1 was admitted under previous ownership on June 9, 2025, with diagnoses including dementia, diabetes, fracture of T11-T12, reduced mobility, weakness, and anxiety. The licensee's change of ownership began on January 15, 2026, and R1 began receiving assisted living services through the new ownership on January 15, 2026. R1's physician orders dated May 27, 2025, included: - Humulin NPH insulin inject 12 units subcutaneously every morning and inject 4 units subcutaneously every evening. R1's Personal Service Plan signed June 9, 2025, indicated because R1 had a diagnosis of diabetes the following were in place: - Be alert to signs of high or low blood sugar: Note that either can present with fatigue, headache, and/or loss of consciousness. High may also display: skin warm and dry, pulse weak and rapid, respiration rapid, blurred vision, vomiting, fruity odor to breath, excessive urination, dry mouth/intense thirst or difficulty concentrating; Low may also display: skin cold and clammy, pulse full and bounding, sweating, shaking, hunger, slurred speech, dizziness, confusion or anxiety. - Perform blood sugar monitoring three or more times per week including equipment calibration and record results. - Perform insulin injections and rotate injection sites. R1's Assessment Summary dated June 9, 2025, indicated the licensee would perform the following services for a certain rate: - Resident has been diagnosed with Diabetes.	02320			

Minnesota Department of Health

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02320	Continued From page 107 - Specific care and/or monitoring because of the chronic condition(s) noted above. - Resident has insulin-dependent diabetes. - Supervise or perform blood sugar monitoring three or more times per week. - Administer insulin injections. R1's Admission Assessment dated March 2, 2026, indicated R1 had a diagnosis of diabetes and received Metformin (oral diabetes medication) and Humulin insulin. R1's assessment did not indicate R1 received blood glucose monitoring. R1's medication administration record (MAR) dated March 2026, included: - Humulin KwikPen NPH insulin administer 12 units subcutaneously in the morning 8:00 a.m. - Humulin KwikPen NPH insulin administer 4 units subcutaneously at 6:00 p.m. In addition, R1's MAR did not include blood glucose monitoring, and there was no evidence in R1's record of blood glucose testing being discontinued. On March 11, 2026, at 9:53 a.m., registered nurse (RN)-B stated she was unaware R1's insulin had been administered at 12:06 p.m. on March 9, 2026. RN-B stated sometimes R1 sleeps in and that may have been why it was not administered until lunch time. RN-B further stated staff should have informed the nurse the insulin was not administered at 8:00 a.m. and followed directions from the nurse. If staff were to administer a medication at a different time, staff should have circled their initials and documented on the back of the sheet when it was administered and the reason it was not administered at the time it was ordered.	02320			

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02320	Continued From page 108 Humulin N prescribing information dated June 2022, indicated the following HUMULIN N is an intermediate-acting insulin with a slower onset of action and a longer duration of activity than that of regular human insulin. In a study in which healthy subjects (n=16) received subcutaneous injections of HUMULIN N (0.4 unit/kg) on 4 occasions, the median maximum effect occurred at 6.5 hours (range: 2.8 to 13 hours) Dosage Information Individualize and adjust the dosage of HUMULIN N based on the individual ' s metabolic needs, blood glucose monitoring results and glycemic control goal. Dosage adjustments may be needed with changes in physical activity, changes in meal patterns (i.e., macronutrient content or timing of food intake), changes in renal or hepatic function or during acute illness CONTRAINDICATIONS HUMULIN N is contraindicated: - During episodes of hypoglycemia Hyperglycemia or Hypoglycemia with Changes in Insulin Regimen Changes in an insulin regimen (e.g., insulin strength, manufacturer, type, injection site or method of administration) may affect glycemic control and predispose to hypoglycemia Make any changes to a patient's insulin regimen under close medical supervision with increased frequency of blood glucose monitoring. Hypoglycemia Hypoglycemia is the most common adverse reaction associated with insulins, including HUMULIN N. Severe hypoglycemia can cause seizures, may be life-threatening or cause death. Hypoglycemia can happen suddenly and symptoms may differ in each patient and change over time in the same patient.	02320			

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02320	Continued From page 109 The licensee's 5.16 Medication and Treatment Record - Documentation and Refusal Policy dated January 15, 2026, indicated the following: - Required Documentation: The following elements must be documented in the resident's medication and/or treatment/therapy records (MAR/TAR) after providing assistance or administration: - The date - The time - The quantity of dosage - The method of administration of all prescribed and over-the-counter medications and/or treatments/therapy - Documentation on the MAR/TAR of the authorized person (initials/signature) who provided the assistance and/or administration. - Documentation of Errors and Omissions 1. Non-Completion: If medication and/or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must immediately include: - The reason why it was not completed (e.g., resident refusal, held due to vital signs, medication unavailable). - Any follow-up procedures that were provided (e.g., RN notified, vital signs retaken). No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remain at I. In addition, the licensee failed to ensure medications were administered according to	02320			

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02320	Continued From page 110 policy and accepted standards of practice for four of four residents (R1, R2, R5, R7). R1 Humulin N On March 9, 2026, at 12:06 p.m., the surveyor observed ULP-G administering Humulin NPH insulin (intermediate acting) to R1. ULP-G removed the insulin pen from the medication cart, cleansed the pen port, attached a pen needle, primed the pen, and administered the insulin to R1. ULP-G did not roll and invert the insulin pen between her hands to mix the insulin prior to administration. On March 10, 2026, at 8:06 a.m., the surveyor observed ULP-C administering Humulin N to R1. ULP-C removed the insulin pen from the medication cart, cleaned the pen port, attached a pen needle, removed both the outer needle shield and the inner needle shield and threw them in the garbage. ULP-C primed the Humulin N pen, and carried the pen with the needle exposed out of the common room, down the hallway, through R1's room and administered the insulin to R1. ULP-C then carried the insulin pen with the needle exposed across R1's room, down the hallway, through the common area, removed the needle and disposed of it in the sharps container. ULP-C did not roll and invert the insulin pen between her hands to mix the insulin prior to administration. On March 10, 2026, at 10:41 a.m., RN-Q stated staff should roll the Humulin N insulin between their hands to mix the insulin prior to administration. Staff should not walk through the common area and down the hall with an exposed needle. Staff had been trained to bring the medication cart with the sharps container to the doorway of the resident's room.	02320			

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02320	Continued From page 111 The licensee's undated, 2.13 Insulin/Auto-inject Pen Subcutaneous Administration procedure included: - gently roll the syringe between your hand to mix insulin that may have settled/separated from suspension; and - unscrew and place used syringe unit in sharps container. Humulin N prescribing information dated June 2022, included: - Gently roll the Pen between your hands 10 times. - Move the Pen up and down (invert) 10 times. Mixing by rolling and inverting the Pen is important to make sure you get the right dose. R2 and R5 diclofenac gel (pain) On March 10, 2026, at 7:38 a.m., the surveyor observed ULP-C administering diclofenac gel to R2. ULP-C took out the measuring strip and placed a very small bead down the center of the 4 gram measuring area, which did not cover the width of the measuring area on the strip. ULP-C wiped the gel into a med cup and the quantity was approximately pea sized. ULP-C then administered the diclofenac to R2's left hip. On March 10, 2026, at 8:00 a.m., the surveyor observed ULP-C administering diclofenac gel to R5. ULP-C took out the measuring strip and placed a very small bead down the center of the 2 gram measuring area, which did not cover the width of the measuring area on the strip. ULP-C wiped the gel into a med cup and the quantity was approximately half of a pea sized amount. ULP-C then administered the gel to R5's bilateral shoulders.	02320			

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02320	Continued From page 112 On March 10, 2026, at 10:41 a.m., RN-B stated staff had been trained the proper way to dose the diclofenac gel and they should have covered the entire dosing area. Voltaren (diclofenac) gel prescribing information dated July 2009, included: - for 2 gram dose - Squeeze Voltaren® Gel onto the dosing card evenly, up to the 2 gram line. Make sure that the gel covers the entire 2 gram area of the dosing card; and - for 4 gram dose - Squeeze Voltaren® Gel onto the dosing card evenly up to the 4 gram line, making sure the gel covers the entire 4 gram area of the dosing card. R7 lidoderm patch On March 10, 2026, at 7:25 a.m., ULP-C removed a lidoderm patch from the box, used a scissors to cut open the package, removed the patch with her ungloved hand, used a marker to put the date on the patch. ULP-C then put on gloves, removed the backing and placed the patch on R7's back. On March 10, 2026, at 10:41 a.m., RN-B stated staff should have worn gloves when removing the patch from the protective package. RN-B then stated if the protective backing was on the patch it would be ok. The licensee's undated, 2.26 Topical Medication Patch Administration indicated staff were to apply gloves prior to opening the patch package. Lidoderm prescribing information dated January 2015, Hands should be washed after the handling of LIDODERM, and eye contact with LIDODERM should be avoided.	02320			

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02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for one of one resident (R7) during medication administration. 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	02410			

Minnesota Department of Health

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02410	Continued From page 114 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 10, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications. ULP-C removed R7's lidoderm patch from the medication cart, opened, removed the patch and initialed it. R7 (female resident) was in the common area with a male resident in the same room. ULP-C approached R7 and told her she was going to apply the patch and R7 leaned forward. ULP-C then lift the back of R7's shirt exposing her up to her mid back. ULP-C then placed the patch on R7's lower back and lowered her shirt. On March 10, 2026, at 10:41 a.m., registered nurse (RN)-Q stated topical medications including a patch should be administered in the resident's room or another private area without other residents. The Minnesota Bill of Rights for Assisted Living Dated January 1, 2026, includes "10. Personal and treatment privacy. Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan" No further information was provided.	02410			

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02410	Continued From page 115 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410			



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

Brookdale West St Paul MC
315 Thompson Avenue East
West St Paul, MN 55118
Dakota County
Parcel:

Phone:
lnelson@wrhills.com

License Info

License: HFID 30684

Risk:
License:
Expires on:
CFPM: Ronald Ransom
CFPM #: 60579; Exp: 4/28/2028

Inspection Info

Report Number: F1031261084
Inspection Type: Full - Single
Date: 3/9/2026 Time: 11am
Duration: ** minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 6
Total Priority 3 Orders: 3
Delivery: Emailed

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

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

COMMENT:

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE.

COPY OF LOG SENT WITH REPORT.

PRINT AND KEEP ILLNESS LOG ON SITE.

FILL OUT LOG WHENEVER SOMEONE CALLS IN OR GOES HOME SICK.

Comply By: 3/9/2026 Originally Issued On: 3/9/2026

New Order: 3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 Priority Level: Priority 2 CFP#: 13

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

COMMENT:

CAN ON CAN RACK FOUND DENTED AT TOP SEAM.

CAN REMOVED FROM STOCK - TO BE RETURNED OR DISCARDED.

MONITOR CONDITION OF CANS PRIOR TO ADDING TO KITCHEN STOCK.

CREATE AND LABEL A LOCATION FOR DENTED CANS TO BE STORED/PLACED.

Comply By: 3/30/2026 Originally Issued On: 3/9/2026

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

3-302.11A(4) Priority Level: Priority 3 CFP#: 15

MN Rule 4626.0235A(4) Protect food from cross-contamination by packages or covered containers.

COMMENT:

OBSERVED UNCOVERED BAG OF FLOUR STORED ON SHEET TRAY IN STORAGE AREA.

PLACE FLOUR IN CONTAINER WITH LID.

Comply By: 3/30/2026 Originally Issued On: 3/9/2026

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs3-302.13 *Priority Level: Priority 1 CFP#: 30*

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

COMMENT:

EGGS BENEDICT WITH HOLLANDAISE SAUCE ON MENU, BUT NO PASTEURIZED EGGS OR
PREMADE/PURCHASED SAUCE ON SITE.

****DISCONTINUE PREPARING UNDERCOOKED UNPASTEURIZED EGGS, OR USING UNPASTEURIZED EGGS FOR
SAUCES/DRESSINGS.****

Comply By: 3/9/2026 Originally Issued On: 3/9/2026

! New Order: 3-500B Microbial Control: hot and cold holding3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT:

1. MULTIPLE ITEMS IN 1-DOOR COOLER (STORAGE AREA) MEASURED > 41F.

****ITEMS DISCARDED****

COOLER OVER-FILLED.

DISCUSSED ORGANIZATION WITH PIC.

REARRANGE COOLER AS DISCUSSED AND CHECK TEMPS IN MORNING.

IF ALL ITEMS ARE NOT AT 41F OR BELOW, HAVE COOLER REPAIRED.

2. BUTTER ON COUNTER MEASURED > 41F.

****BUTTER DISCARDED****

DISCONTINUE STORING BUTTER ON COUNTER.

DISCUSSED TAKING OUT WORKING STOCK OF BUTTER PRIOR TO MEALS, SO BUTTER CAN SOFTEN.

DISCARD REMAINING AFTER 4HRS.

Comply By: 3/9/2026 Originally Issued On: 3/9/2026

New Order: 3-500C Microbial Control: date marking3-501.17A *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT:

ESTABLISHMENT IS NOT DATE MARKING FOODS.

FOLLOW ABOVE DIRECTION.

DISCARD ALL DATE MARKED ITEMS AFTER 7 DAYS.

Comply By: 3/12/2026 Originally Issued On: 3/9/2026

New Order: 4-300 Equipment Numbers and Capacities4-302.12B *Priority Level: Priority 2 CFP#: 36*

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

COMMENT:

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 3/12/2026 Originally Issued On: 3/9/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT:

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE.

PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 3/12/2026 Originally Issued On: 3/9/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT:

1. ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.

PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

2. VEG WASH STRIPS EXPIRED. PURCHASE NEW STRIPS.

Comply By: 3/12/2026 Originally Issued On: 3/9/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT:

ESTABLISHMENT DOES NOT HAVE SANITIZER BUCKETS PREPARED.

PIC STATED A KEY TO MECHANICAL ROOM IS NEEDED TO GET SANI SOLUTION.

HAD PIC GET KEY AND FILL SANI BUCKET.

MAKE KEY FOR MECHANICAL ROOM AND PLACE/HANG IN KITCHEN, SO STAFF CAN FILL/REPLACE BUCKETS AS NEEDED.

Comply By: 3/12/2026 Originally Issued On: 3/9/2026

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT:

TRUE 1-DOOR COOLER IN STORAGE AREA MAY NOT BE WORKING PROPERLY.

VERIFY TEMP OF COOLER AND REPAIR IF NEEDED.

Comply By: 3/9/2026 Originally Issued On: 3/9/2026

New Order: 6-300 Physical Facility Numbers and Capacities6-301.12 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT:

HANDWASH STATION MISSING PAPER TOWELS.

HAD STAFF FILL PAPER TOWELS.

IMMEDIATELY FILL TOWELS ONCE EMPTY.

Comply By: Complied On Site Originally Issued On: 3/9/2026

Food & Beverage General Comment

Majority of kitchen area is a commercial kitchen.

Cabinets and wall coverings are not approved, but flooring, ceiling, equipment and countertops are.

Location has handwash sink, prep sink, and 2-comp sink, but no 3-comp sink.

Keep painted walls and cabinetry clean and maintained. If not kept clean and maintained, MDH may required items to be updated with approved items.

NOTES:

1. Do not place liquids in wood cabinetry. Store liquids on approved shelving.
2. No unpasteurized eggs are to be prepared less than 145F (no eggs Benedict or Hollandaise with raw egg). Purchase pasteurized eggs if intending to serve eggs undercooked or make raw egg sauces.
3. Person in kitchen requires access to sanitizer at ALL TIMES. Since sanitizer dispenser is in locked mechanical closet, a key should be made and placed in kitchen for food service access.

Nurse Evaluator on site: Stacy Haag

All violations discussed with PIC during the inspection.

- Prior to beginning prep work, staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Employee food needs to be labeled and separated from residents' food.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.
- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- When cooking/preparing food, make sure to use a thin-probe thermometer to check temperatures.

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.

Report Number: F1031261084
Inspection Type: Full
Date: 3/9/2026

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I acknowledge receipt of the Metro District Office inspection report number F1031261084 from 3/9/2026



Casey Milburn
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@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

Brookdale West St Paul MC
West St Paul
County/Group: Dakota County

Inspection Info

Report Number: F1031261084
Inspection Type: Full
Date: 3/9/2026
Time: 11am

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

Location: Cambro on Counter at 74 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: 1-Door Cooler (storage area) at 45 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** Steak in Gravy; **Temperature Process:** Cold-Holding

Location: 1-Door Cooler (storage area) at 45 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: 1-Door Cooler (storage area) at 50 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: 1-Door Cooler (top) (storage area) at 42 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: 1-Door Cooler (cook line) at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Chicken Cordon Blu; **Temperature Process:** Cooking

Location: Pan on Oven at 210 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Brookdale West St Paul MC
West St Paul
County/Group: Dakota County

Inspection Info

Report Number: F1031261084
Inspection Type: Full
Date: 3/9/2026
Time: 11am

Sanitizing Equipment: **Product:** Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 169.3 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Equipment: **Product:** Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: Mechanical Room **Equal To** 200 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Equipment: **Product:** Produce Wash; **Sanitizing Process:** Dispenser

Location: Kitchen **Equal To** 701 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30684016-0	Date: 3/9/2026
Facility Name: BROOKDALE WEST ST PAUL MC	
Facility Address: 315 THOMPSON AVE E, WEST ST. PAUL, MN 55118	

☒ 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. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: Facility controlled egress system was not equipped with a separate de-activate button or switch in the fire command center or other approved location to unlock the system.

3. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

Comments: In various locations throughout the facility, different sprinkler heads had missing or loose escutcheons.

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

alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: Facility only had hard-wired carbon monoxide alarms outside of each mechanical room. The fuel-fed water heaters and HVAC system didn't have carbon monoxide alarms connected to the fire alarm or in each resident room.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: Licensee had the FSEP in a locked supply closet; provided FSEP was not current with new management company. Licensee failed to provide updated plans to the facility staff since management began on January 15, 2026.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. 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: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP didn't included standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

5. 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: Licensee lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan.

6. 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: Licensee lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

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

Comments: Licensee lacked documentation showing any evacuation drills occurred. No other information or documentation was provided.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: The documentation provided was a hazard vulnerability assessment (HVA) that included the identification of global risk factors like severe weather, wildfires, epidemics, systems failures, and civil disturbances. There was no documentation provided for a safety risk assessment performed on and around the property.