



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 27, 2026

Licensee

HealthPoint HWS @ 93rd
351 93rd Avenue Northeast
Blaine, MN 55434

RE: Project Number(s) SL34173017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 3, 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 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Thorson". The signature is written in dark ink and is positioned below the word "Sincerely,".

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER HEALTHPOINT HWS @ 93RD			STREET ADDRESS, CITY, STATE, ZIP CODE 351 93RD AVENUE NE BLAINE, MN 55434		
(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: SL34173017-0 On June 29, 2026 through July 1, 2026 the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4) residents; four (4) receiving services under the Assisted Living Facility license. An immediate correction order was identified on June 30, 2026, issued for SL34173017-0, tag identification 0775.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders for a survey completed on April 11, 2024. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 340			

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0 340	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 29, 2026, at 11:06 a.m., the surveyor requested to see the plan of correction (POC) from the previous survey. On June 29, 2026, at 12:40 p.m., housing manager/unlicensed personnel (HM/ULP)-B stated she is unable to find the POC and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A would get it for me tomorrow. On July 1, 2026, at 2:25 p.m., LALD/CNS-A stated he was not aware that a POC from previous survey was required and this would be the reason he does not have one, he remembers completing a plan of correction from the survey but is unable to find it. The licensee did not provide POC documentation to indicate corrective actions taken related to correction orders previously cited on April 11, 2024. Upon conclusion of the survey initiated on June 29, 2026, the following areas previously cited remained out of compliance: - tag identification number 0650 related to postings of the staff records; - tag identification number 0660 related to Tuberculosis prevention and control; - tag identification number 0680 related to disaster planning and emergency preparedness plan; - tag identification number 1470 related to content of required orientation; - tag identification number 1500 related to required annual training;	0 340			

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0 340	Continued From page 3 - tag identification number 1620 related resident reassessment and monitoring; and - tag identification number 1880 related to storage of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650			

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0 650	Continued From page 4 Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees housing manager/unlicensed personnel (HM/ULP)-B and registered nurse (RN)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM/ULP-B HM/ULP-B was hired on January 8, 2025, to provide assisted living services. HM/ULP-B's personnel record lacked documentation of the following: - records of orientation to include all required topics; - records of annual training to include all required topics; - records of competency evaluation to include: - prosthetic leg; - continuous positive airway pressure (CPAP); and - documentation of an annual performance review. RN-C RN-C was hired on June 7, 2024, to provide clinical oversight and assisted living services.	0 650			

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0 650	Continued From page 5 RN-C's personnel record lacked documentation of the following: - records of orientation to include all required topics; - records of annual training to include all required topics; and - documentation of an annual performance review. On July 1, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he does not have annual performance reviews for any employees, he did not realize this was required. On July 1, 2026, at 1:20 p.m., LALD/CNS-A stated all the employees would be missing the review of the uniform disclosure of assisted living services and amenities (UDALSA). On July 1, 2026, at 1:45 p.m., LALD/CNS-A stated all the employees would be missing some or all of the annual training due to it being assigned incorrectly or has not been completed by the staff. The licensee's undated 4.05 Employee Records policy, indicated Employee records for each person will include: - records of all training and in service education required and/or provided including record of competency testing as required; - documentation of annual performance reviews that identify areas of improvement needed and training needs; and - verification of completed orientation and annual training and competency testing as required. No further information was provided.	0 650			

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0 650	Continued From page 6	0 650			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB history and symptom screen and baseline TB screening by completion of a two-step tuberculin skin test (TST), TB blood test, or documented history of positive TB test with the required follow up chest x-ray for two of two employees (house manager/unlicensed personnel (ULP)-B and registered nurse (RN)-C). This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 7 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: The licensee's Facility TB Risk Assessment, dated January 2026, indicated the facility was at a low risk for TB transmission. HM/ULP-B HM/ULP-B was hired January 8, 2025, to provide direct care servoces for residents. HM/ULP-B's record included a TB history and symptom screen dated January 13, 2025, that was not signed by HM/ULP-B and a one-step TST dated January 21, 2025, but lacked the second step of the skin test. On June 30, 2026, at 2:25 p.m., HM/ULP-B stated she could not find the TB history and symptom screen and only had a one-step skin test because she had a reaction to the first test, and the clinic advised her not to get another one. RN-C RN-C was hired on June 7, 2024, to provide clinical oversight and assisted living services. RN-C's record included a negative chest x-ray dated June 15, 2023, but lacked documentation of TB history and symptom screen and either a previous positive TB test or documentation of completion of TB treatment, correlated to the	0 660			

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0 660	Continued From page 8 chest x-ray. The test was also more than 90 days prior to hire date. On July 1, 2026, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agreed some of the employees are missing a piece of the TB testing. LALD/CNS-A stated RN-C was missing the TB history and symptom screen and a positive TB test to indicate the need for a chest x-ray, he thought the chest x-ray was sufficient and did not realize the test needed to be withing 90 days prior to hire to be used. The licensee's undated 8.16 Tuberculosis Screening policy indicated Screening will be conducted as follows: - New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs . - New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. - No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. - Staff TB screening results will be kept in each employee medical file. - Staff should be screened for signs and symptoms on an annual basis. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB	0 660			

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0 660	Continued From page 9 disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680			

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0 680	Continued From page 10 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's EPP dated January 5, 2026, lacked the required content: - a quarterly review of missing resident policy; - identify program patient population; - process for EPP collaboration with local officials; - the development of policies/procedures to address: - volunteers; and - arrangement with other facilities; - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians,	0 680			

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0 680	Continued From page 11 other facilities, volunteers, and other facilities; - methods for sharing information and medical documentation for residents under the facilities care; - methods for sharing information on occupancy needs; and - documentation EPP exercise has been tested twice a year. On July 7, 2026, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agrees the EPP is missing some of the required information, he thought the fire drills would be considered an EPP drill and did not realize some of the other information was missing from the EPP but will need to update the EPP to include all required information. The licensee's Emergency Preparedness policy dated March 11, 2022, indicated licensee's will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency disaster that disrupts services. The licensee's Missing Resident policy dated March 11, 2022, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided.	0 680			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HEALTHPOINT HWS @ 93RD			STREET ADDRESS, CITY, STATE, ZIP CODE 351 93RD AVENUE NE BLAINE, MN 55434		
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0 680	Continued From page 12	0 680			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect two residents and all staff. 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: On June 30, 2026, at 10:15 a.m., the surveyor toured the facility with house manager (HM)-B. The egress windows in occupied resident sleeping rooms were opened by HM-B and measured by the surveyor. The egress windows in occupied resident bedrooms A and C did not meet the minimum requirements for safe egress. OCCUPIED SLEEPING ROOMS	0 775			

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0 775	Continued From page 13 Non-compliant egress window measurements: Occupied bedroom A - the clear open area of both windows measured 17 inches clear width, 49 inches clear height, with a total clear open area of 833 square inches. Occupied bedroom C - the clear open area of the window measured 26.5 inches clear width, 21.5 inches clear height, with a total clear open area of 569.75 square inches. The windows in bedrooms A did not meet the minimum requirements for clear opening width. The window in bedrooms C did not meet the minimum requirements for total openable area. One window in each resident bedroom room must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During the facility tour interview, HM-B verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) day.	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780			

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0 780	Continued From page 14 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 780			

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0 780	Continued From page 15 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=B	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 790			

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0 790	Continued From page 16 interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810			

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0 810	Continued From page 18 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, record review, and interview, 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	0 810			

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0 810	Continued From page 19 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, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 830			

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0 830	Continued From page 20 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced	0 910			

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0 910	Continued From page 21 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include assistance with dressing, grooming, toileting, transfer assistance, meal preparation, medication administration, behavior monitoring, blood glucose monitoring and assistance with prosthetic leg. R1's record contained a signed contract dated March 29, 2026. The contract contained the licensee's license number but lacked documentation of the licensee's Health Facility Identification (HFID) number. On July 1, 2026, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the HFID is missing from the contract, he has the license number instead of the HFID so he will need to update the contract	0 910			

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0 910	Continued From page 22 and uses the same contract for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 15,	0 970			

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0 970	Continued From page 23 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include assistance with dressing, grooming, toileting, transfer assistance, meal preparation, medication administration, behavior monitoring, blood glucose monitoring and assistance with prosthetic leg. R1's Assisted Living Contract dated March 29, 2026, included the following language under the Miscellaneous Provisions sections, "The resident agrees that [licensee's name] will not be liable to the resident for the any personal injury or property damage," and "The resident hereby releases [licensee's name] from liability for any personal injury or property damage suffered by the resident." On July 1, 2026, at 11:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he just updated all the resident contracts to take out that the facility is not liable for personal injury, but must have missed taking this part out and will need to update them again. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470			

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01470	Continued From page 24 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470			

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01470	Continued From page 25 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (housing manager/unlicensed personnel (HM/ULP)-B, and registered nurse (RN-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM/ULP-B	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER HEALTHPOINT HWS @ 93RD			STREET ADDRESS, CITY, STATE, ZIP CODE 351 93RD AVENUE NE BLAINE, MN 55434		
(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
01470	Continued From page 26 HM/ULP-B was hired on January 8, 2025, to provide assisted living services. HM/ULP-B's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - review of types of Assisted Living services the employee will provide and provider's scope of license. RN-C RN-C was hired on June 7, 2024, to provide clinical oversight and assisted living services. RN-C's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - overview of Assisted Living Statutes; - review of provider's policies and procedures; - handling of resident complaints, reporting complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principals of person-centered planning/service delivery. On July 1, 2026, at 1:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all the employees would be missing the review of Assisted Living Services because he did not know it was required and some of the other staff are missing some of the required topics due to it being assigned incorrectly or they have not completed it and he will take responsibility for this error. The licensee's undated 4.18 Employee General	01470			

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01470	Continued From page 27 Orientation policy indicated Upon hire and prior to performing any functions of their position at licensee each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500			

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01500	Continued From page 28 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, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment that included the required annual training content for two of two employees (housing manager/unlicensed personnel (HM/ULP)-B and registered nurse (RN)-C).	01500			

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01500	Continued From page 29 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: HM/ULP-B HM/ULP-B was hired on January 8, 2025, to provide assisted living services. HM/ULP-B's transcript lacked any annual training for 2026. HM/ULP-S record lacked the following required annual training topics: - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - infection control techniques; - effective Approaches to use to problem solve when working with a residence challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of providers policies and procedures; and - principles of person centered planning/service delivery. RN-C RN-C was hired on June 7, 2024, to provide clinical oversight and assisted living services. RN-C's transcript indicated RN-C had completed	01500			

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01500	Continued From page 30 annual training in the following topics for a total of 7.75 hours: - emergency preparedness - human hazards, completed March 18, 2025 - 0.75 hours; - vulnerable adult, completed October 20, 2025 - 1.25 hours; - emergency preparedness and disaster planning, completed February 10, 2026 - 0.75 hours; - Parkinson's disease, completed March 16, 2026 - 0.75 hours; - dining, nutrition, and food safety, completed March 19, 2026 - 1.25 hours; - dementia management and abuse prevention, completed March 20, 2026 - 1.25 hours; - emergency preparedness - overview, completed March 20, 2026 - 0.75 hours; and - mental illness - response strategies, completed March 20, 2026 - 1.00 hours. RN-C's record lacked the following required annual training topics: - Assisted Living Bill of Rights; - infection control techniques; - effective Approaches to use to problem solve when working with a residence challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of providers policies and procedures; and - principles of person centered planning/service delivery. HM/ULP-B and RN-C's records both lacked the required eight (8) hours per 12 months of employment. On July 1, 2026, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor(LALD/CNS)-A stated all the employees are missing some or all of the	01500			

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01500	Continued From page 31 required annual training topics and required hours due to him not assigning the classes correctly or some have been assigned just not completed. The licensee's undated 5.06 Annual Required Staff Training policy indicated All staff that perform direct care services at licensee will complete at least eight (8) hours of annual training for each 12 months of employment. The following training elements must be included every 12 months to all staff who performs direct care services: - training on reporting of maltreatment of vulnerable adults under section 626. 557; - review of the assisted living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for an use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, in razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - 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; - review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500			

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01500	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the	01530			

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01530	Continued From page 33 requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within 160 working hours of employment for direct care staff as required for one of two employees (housing manager/unlicensed personnel (HM/ULP)-B). Additionally, the licensee failed to ensure direct care staff completed two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for two of two employees (HM/ULP-B and registered nurse (RN)-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 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: HM/ULP-B was hired on January 8, 2025, to provide assisted living services.	01530			

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01530	Continued From page 34 HM/ULP-B's transcript indicated HM/ULP-B had completed 7.75 hours of initial dementia care training and 1 hour of mental illness and de-escalation training. HM/ULP-B's record lacked documentation of the required initial eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of hire. RN-C RN-C was hired on June 7, 2024, to provide clinical oversight and assisted living services. RN-C's transcript indicated RN-C had completed 1 hour of initial mental illness and de-escalation training. RN-C's employee record lacked documentation of the required initial two hours of mental illness and de-escalation training within 160 hours of hire. On July 1, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated HM/ULP-B was lacking .25 hours of initial dementia training and all the employees would be missing the required 2 hours of initial mental illness and de-escalation training, he must have not assigned enough dementia training for HM/ULP-B and did not realize it was 2 hours of initial mental illness and de-escalation training required, he thought it was 1 hour. The licensee's undated 5.03 Dementia Training policy indicated Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date The licensee's policies did not address the new statutory requirement to provide mental illness	01530			

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01530	Continued From page 35 and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A	01620			

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01620	Continued From page 36 registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1 and 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 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:	01620			

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01620	Continued From page 37 R1 On June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include assistance with dressing, grooming, toileting, transfer assistance, meal preparation, medication administration, behavior monitoring, blood glucose monitoring and assistance with prosthetic leg. R1's record included 90-day nursing assessments dated September 13, 2025, December 15, 2025, and March 10, 2026. The assessment completed on December 15, 2025, was three (3) days past the 90-calendar day requirement and the assessment currently due on June 8, 2026, was 21 days past due. R2 On June 30, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's was admitted to the licensee on February 27, 2025, with diagnoses which included antisocial personality disorder, attention deficit hyperactive disorder (ADHD), Traumatic brain injury in substance use disorder. R2's Service Plan signed February 27, 2025,	01620			

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01620	Continued From page 38 indicated R2 received assistance with meal assistance, behavior monitoring, medication administration, cleaning, shopping and laundry. R2's record included 90-day nursing assessments completed on September 9, 2025, December 15, 2025, and March 18, 2026. The assessment completed on December 15, 2025, was seven (7) days past the 90-calendar day requirement, and the assessment completed on March 18, 2026, was three (3) days past the 90-calendar day requirement and the assessment currently due June 16, 2026, was eight (8) days past due. On June 30, 2026, at 2:15 p.m., registered nurse (RN)-C stated she is completing the assessments on time but not charting them in the computer until later and this is why they show late. On July 1, 2026, at 9:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all the resident assessments are going to be late in the system because the nurse is charting them late in the computer. LALD/CNS-A agreed the assessments should be completed in person and charted the same day they are completed. The licensee's undated 6.01 Assessment, Reviews & Monitoring policy indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided.	01620			

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01620	Continued From page 39	01620			
01650 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01650			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 40 review, the licensee failed to ensure the service plan included the correct required content for two of two residents (R1 and 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). The findings include: R1 On June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include assistance with dressing, grooming, toileting, transfer assistance, meal preparation, medication administration, behavior monitoring, blood glucose monitoring and assistance with prosthetic leg. R2 On June 30, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2.	01650			

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01650	Continued From page 41 R2's was admitted to the licensee on February 27, 2025, with diagnoses which included antisocial personality disorder, attention deficit hyperactive disorder (ADHD), Traumatic brain injury in substance use disorder. R2's Service Plan signed February 27, 2025, indicated R2 received assistance with meal assistance, behavior monitoring, medication administration, cleaning, shopping and laundry. R1 and R2's service plans included the following required content: - a description of the services to be provided and the frequency of each service, according to the residents' current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R1 and R2's service plans lacked the following required content:	01650			

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01650	Continued From page 42 - the fees for service; and - information and a method to contact the facility. On July 1, 2026, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all the current signed service plans are the same and on paper, he agrees they are missing a fee for service and a method to contact the facility, he did not realize the paper service plans were missing some of the required content and will need to update them. The licensee's undated 6.08 Service Plan policy indicated the service plan will include: - a description of the services to be provided based on the most recent assessment and resident preferences; - Fees for services to be provided; - the frequency of each service to be provided based on the most recent assessment and resident preferences; - an identification of staff or categories of staff who will be providing services; - a schedule and method for the next planned assessment or monitoring; - a schedule and method for the next plan monitoring of staff providing services; - a contingency plan that includes: - actions licensee will take if scheduled services cannot be provided; - information regarding how the resident can contact licensee; - The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and - how the facility will support documented	01650			

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01650	Continued From page 43 resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01720 SS=D	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion 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 discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for one of one (R1) reviewed. 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:	01720			

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01720	Continued From page 44 On June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include medication administration. R1's Medication Administration Record (MAR) dated May 1, 2026, through May 31, 2026, indicated R1 had not taken polyethylene glycol 17 grams for 22 of the 31 days. R1's MAR dated June 1, 2026, through June 30, 2026, indicated R1 had not taken polyethylene glycol 17 grams for 17 of the 30 days. R1's record lacked documentation of discussion and education provided to R1 on possible consequences of the refusal of medications, or updates to the provider regarding the missed medications. On July 1, 2026, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agrees the staff are not putting a reason for why the medication was not given, and there has not been any follow up by the nurse to document a discussion of the refusals or follow up with the provider to advise of the consistent resident refusals and this must have been missed by them. The licensee's undated 7.22 Medication and Treatment Record - Documentation and Refusal	01720			

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01720	Continued From page 45 policy indicated If medication and/or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of two residents (R1) who received medication management services.	01750			

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01750	Continued From page 46 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 On June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. ULP-D stated he will verify the medications with the MAR, crush them, and put them into applesauce because this is how R1 takes his morning medications. ULP-D stated he thinks it is in the MAR to crush the medications. R1 crushed all of R1's morning medications and placed them in a cup of applesauce. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include medication administration. R1's June 2026 Medication Administration Record (MAR) indicated R1 was scheduled the following medications: - losartan potassium 25 milligrams (mg), take ½ tablet by mouth daily for high blood pressure; - tab-a vite, take one tablet daily for multivitamin;	01750			

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01750	Continued From page 47 - vitamin D 50 micrograms (mcg), take one tablet by mouth daily for vitamin D deficiency; - clopidogrel 75 mg, give one tablet by mouth in the morning for prevention of blood clots, medications are to be crushed and given with yogurt or applesauce; - famotidine 20 mg, give one tablet by mouth once daily for heartburn; - Jardiance 10 mg, take one tablet by mouth for diabetes; - levothyroxine 50 mcg, take one tablet by mouth before breakfast for hypothyroidism; - metoprolol tartrate 25 mg, give ½ tablet by mouth twice daily for high blood pressure; - rosuvastatin 20 mg, take one tablet by mouth daily for high cholesterol; - vitamin B-12 1000mcg, take one tablet by mouth daily for vitamin B supplement; - polyethylene glycol 17 grams, dissolve 17 grams in 8 oz. of liquid and drink by mouth daily for constipation; - Lantus Solostar 100 units/ml, inject 3 units subcutaneously before bedtime; and - tamsulosin 0.4 mg, take one capsule by mouth at bedtime. R1's MAR lacked specific instructions documented in the residents' record that included: - crush all medications and give in applesauce. On July 1, 2026, at 11:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agrees the specific instructions to crush medications is not in R1's MAR, the nurse would be responsible for making sure any instructions are in the MAR and the reason the specific instructions are not in the MAR is due to the nurse not transcribing the information correctly into the MAR.	01750			

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01750	Continued From page 48 The licensee's undated 7.15 Medication & Treatment -Administration & Delegation policy indicated When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee will ensure that the registered nurse has: - specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure there was a current, written, or electronically recorded prescription for prescribed medications that the assisted living facility was managing 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	01820			

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01820	Continued From page 49 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 June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include medication administration. R1's June 2026 Medication Administration Record (MAR) indicated R1 was scheduled the following medications: - losartan potassium 25 milligrams (mg), take ½ tablet by mouth daily for high blood pressure; - tab-a vite, take one tablet daily for multivitamin; - vitamin D 50 micrograms (mcg), take one tablet by mouth daily for vitamin D deficiency; - clopidogrel 75 mg, give one tablet by mouth in the morning for prevention of blood clots, medications are to be crushed and given with yogurt or applesauce; - famotidine 20 mg, give one tablet by mouth once daily for heartburn; - Jardiance 10 mg, take one tablet by mouth for diabetes; - levothyroxine 50 mcg, take one tablet by mouth before breakfast for hypothyroidism; - metoprolol tartrate 25 mg, give ½ tablet by mouth twice daily for high blood pressure;	01820			

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01820	Continued From page 50 - rosuvastatin 20 mg, take one tablet by mouth daily for high cholesterol; - vitamin B-12 1000mcg, take one tablet by mouth daily for vitamin B supplement; - polyethylene glycol 17 grams, dissolve 17 grams in 8 oz. of liquid and drink by mouth daily for constipation; - Lantus Solostar 100 units/ml, inject 3 units subcutaneously before bedtime; and - tamsulosin 0.4 mg, take one capsule by mouth at bedtime. R1's record lacked a signed physician's order for the following medications: - vitamin D 50 micrograms (mcg), take one tablet by mouth daily for vitamin D deficiency; - famotidine 20 mg, give one tablet by mouth once daily for heartburn; - Jardiance 10 mg, take one tablet by mouth for diabetes; - levothyroxine 50 mcg, take one tablet by mouth before breakfast for hypothyroidism; - vitamin B-12 1000mcg, take one tablet by mouth daily for vitamin B supplement; - polyethylene glycol 17 grams, dissolve 17 grams in 8 oz. of liquid and drink by mouth daily for constipation; and - Lantus Solostar 100 units/ml, inject 3 units subcutaneously before bedtime. On July 1, 2026, at 10:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 is missing some of his signed orders because they were sent out to the provider in March and they have not received them back due to the provider being on maternity leave but has signed orders for all of the other residents. LALD/CNS-A stated it was the nurse's responsibility to get signed orders for all medications they are administering.	01820			

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01820	Continued From page 51 The licensee's undated 7.20 Medication and Treatment Orders policy indicated an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the residents nursing assessment. Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow up with the prescriber's office until the signature is received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01880			

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01880	Continued From page 52 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 30, 2026, at 8:25 a.m., the surveyor observed the unlocked medication cart located in the living room area of the facility. Unlicensed personnel (ULP)-D stated R1 came out a little bit ago before the surveyor arrived and he unlocked the medication cart. R1 was not ready to take his medications yet, so when R1 went back to his room, he had forgotten to lock the medication cart back, but it is normally always locked. On June 30, 2026, at 8:45 a.m., ULP-D completed medication administration with R3, went to the computer desk located in the living room, charted the medications on the computer and left the keys laying on the desk and left the room to go into the kitchen. On June 30, 2026, at 9:00 a.m., ULP-D retrieved the keys from the computer desk and unlocked the medication cart and proceeded to administer medications for R2. ULP-D completed the medication administration, charted the medications in the computer, and then placed the keys on a hook in the living room. On July 1, 2026, at 11:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agreed the unlocked medication cart, leaving the keys laying around on the computer desk and hanging the keys from a hook in the living room would all be breaches in medication security and the staff working should	01880			

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01880	Continued From page 53 have the keys on their person at all times. The licensee's undated 7.11 Medication Storage policy indicated Medications managed by licensee will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a residence private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 54 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (housing manager/unlicensed personnel (HM/ULP-B) demonstrated competency in continuous positive airway pressure and orthotic brace to a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 29, 2026, at 10:00 a.m., HM/ULP-B stated the licensee currently provided treatment management services of CPAP, blood glucose monitoring and prosthetic legs assistance to the residents of the facility. HM/ULP-B was hired on January 8, 2025, to provide assisted living services. HM/ULP-B's employee record lacked competencies for CPAP and orthotic braces. On July 1, 2026, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated HM/ULP-B's record is	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2026
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01950	Continued From page 55 missing the competencies for CPAP and the prosthetic leg because he thought the training itself was sufficient and the resident's only need assistance with the CPAP and the prosthetic leg occasionally not everyday. The licensee's undated 5.02 Competency Training Evaluations policy indicated Additional nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by an RN include: - leg braces; and - CPAP machines. A copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were	01970			

Minnesota Department of Health

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01970	Continued From page 56 maintained for one of two residents (R1) receiving treatments. 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 June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D monitor blood glucose and administer medications to R1. R1 was admitted to the licensee on April 15, 2020, and started to receive assisted living services August 1, 2021, with diagnoses which included diabetes type 2, amputation below the right knee, and peripheral vascular disease. R1's signed Service Plan dated May 3, 2023, indicated R1 received assisted living services to include assistance with dressing, grooming, toileting, transfer assistance, meal preparation, medication administration, behavior monitoring, blood glucose monitoring and assistance with prosthetic leg. R1's Service Recap Summary dated June 2026, indicated staff provid assistance with blood glucose monitoring four (4) times daily and assistance with prosthetic leg three (3) times daily. R1's record lacked signed prescriber's orders for	01970			

Minnesota Department of Health

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01970	Continued From page 57 blood glucose monitoring and assistance with prosthetic leg. On July 1, 2026, at 10:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he does not have signed provider orders for blood glucose monitoring or assistance with prosthetic leg, all he has is an unsigned after visit summary (AVS), he sent orders to the provider in March but has not received them back due to the provider is on maternity leave. The licensee's undated 7.20 Medication and Treatment Orders policy indicated an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the residents nursing assessment. Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow up with the prescriber's office until the signature is received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02320 SS=F	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	02320			

Minnesota Department of Health

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02320	Continued From page 58 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 record review, the licensee failed to ensure the steps of the medication administration process were followed for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 29, 2026, at 10:00 a.m., housing manager/unlicensed personnel (HM/ULP)-B stated they provided medication management services to all four residents living at the facility. On June 30, 2026, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications for R1. ULP-D opened the medication cart and took out a card that included all of R1's medications. The medications were packaged in weekly cards that contained all medications scheduled for the same time and day in one bubble. ULP-D verified the medications briefly one time on the computer before he opened the bubble, placed the medications into a pill crusher, placed the crushed medication into a	02320			

Minnesota Department of Health

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02320	Continued From page 59 cup of applesauce, and administered them to R1. ULP-D placed the medication card into the medication cart and went to computer to chart the medications as administered. ULP-D stated he knew what the six (6) rights and three (3) checks of medication administration were and only did one check today because he was being observed and he was nervous, but he normally does the six (6) rights and three (3) checks. On June 30, 2026, at 8:45 a.m., the surveyor observed ULP-D administer medications for R3. ULP-D removed the medication card from the medication cart and went to the computer and verified the medications one time before placing the medications into a medication cup and handed the cup to R3. ULP-D did not watch to see if R3 took the medications, walked over to the medication cart to put the medication card back in, then to the computer and proceeded to chart the medications as administered. On June 30, 2026, at 9:00 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D opened the medication cart and took out the medication card that contained the scheduled medications and also took out two medication cards that contained as needed (PRN) medications. The PRN medications were acetaminophen and methocarbamol both prescribed for pain. ULP-D verified the scheduled medication one time on the computer but failed to verify the PRN medications. ULP-D failed to ask R2 if he wanted PRN medications and R2 did not request the PRN medications. ULP-D placed all the medications into a medication cup and administered them to R2. ULP-D stated R2 takes the PRN medications every morning for body aches so he does not ask anymore if R2 would like them just adds them into the scheduled	02320			

Minnesota Department of Health

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02320	Continued From page 60 medications. ULP-D placed the medication cards back into the medication cart and charted the medications as administered on the computer and put the reason for PRN's was pain. On July 1, 2026, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-D did not follow proper medication administration procedure if he did not complete the six (6) rights and three (3) checks of medication administration and PRN medications should not be given unless requested by the resident or at the least discussed with the resident prior to administration. The licensee's undated 6.14 Delegation of Assisted Living Services policy indicated a registered nurse or licensed health professional at licensee may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The licensee's undated 7.27 PRN Medications policy indicated Only properly trained staff of licensee may provide PRN medication administration. Procedure: - review the residence medication sheet at the time of administering medication; - check the information of the individual medication sheet for: - right person; - right medication; - right time; - right route; - right dose; and - rate chart/record to document that the medication was taken. - check frequency of PRN medication if given in	02320			

Minnesota Department of Health

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02320	Continued From page 61 the last 24 hours and whether it has been given the maximum number of times allowable for the day; - confirm whether the reasoning for giving the medication matches the reason the medication is prescribed; - check the medication sheet in the medication book with the label on the medication container. The label should be checked three (3) times. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Healthpoint HWS @93rd
351 93RD AVENUE NE
Blaine, MN 55434
Anoka County
Parcel:

Phone:

License Info

License: HFID 34173

Risk:
License:
Expires on:
CFPM: Gamada Butta
CFPM #: 60867; Exp: 8/20/2028

Inspection Info

Report Number: F7963261079
Inspection Type: Full - Single
Date: 6/30/2026 Time: 12:23:37 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH ESTABLISHMENT REPRESENTATIVES ALICEA LONDON AND RAJI GASHU AND MSH NURSE SURVEYOR SARABETH REMKER. DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICY AND LOG
- REPORTABLE DISEASES
- VOMIT/FECAL CLEAN UP POLICY
- DEFINITION OF SAME-DAY FOODSERVICE
- STORAGE OF SHELL EGGS
- COLD HOLDING OF FOODS

THIS IS A RESIDENTIAL KITCHEN USING SAME-DAY FOODSERVICE. DISH/UTENSIL WASHING AND SANITIZING IS DONE WITH A RESIDENTIAL DISHWASHER.

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

I acknowledge receipt of the Metro District Office inspection report number F7963261079 from 6/30/2026

Alicea London
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@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

Healthpoint HWS @93rd
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F7963261079
Inspection Type: Full
Date: 6/30/2026
Time: 12:23:37 PM

Food Temperature: Product/Item/Unit: MILK; Temperature Process:

Location: REFRIGERATOR at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: HOT DOGS; Temperature Process:

Location: REFRIGERATOR at 36 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

Healthpoint HWS @93rd
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F7963261079
Inspection Type: Full
Date: 6/30/2026
Time: 12:23:37 PM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:**

Location: SANI BUCKET **Equal To** 400 PPM

Comment:

Violation Issued?: No

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

Location: DISHWASHER RINSE **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34173017-0	Date: June 30, 2026
Facility Name: Health Point HWS@93rd	
Facility Address: 351 93 rd Avenue NE, Blaine, MN 55434	

☒ TAG IDENTIFICATION: 0775	
SCOPE/ SEVERITY: Level 3; Widespread	TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A means of egress shall be free from obstructions that would prevent its use. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: A wood ladder was installed in the egress window well for occupied resident bedroom D. The ladder prevented the egress window from opening to provide a clear open width of at least twenty inches. When ladders are installed in egress window wells, these ladders must not obstruct the emergency escape and rescue opening of the window in any way.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Extension cords were used to supply power in occupied resident bedrooms B and C, and in the upper level office.

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

Comments: The covers were missing from several electrical wall outlets in the basement living room. House manager (HM)-B stated these covers had been removed for the remodeling project. Electrical outlet covers shall be installed to prevent accidental contact with live electrical components by the building occupants.

5. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: In the detached garage, the area in front of the electrical panel was used for storage. The minimum working space requirements in front of the panel were not met.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: A smoke alarm was not installed in occupied resident room D. House manager (HM)-B stated they were not aware this smoke alarm had been removed.

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

Comments:

- When house manager (HM)-B tested the dwelling unit wireless smoke alarm system, the smoke alarm in occupied resident bedroom A was not actuated. The smoke alarm in bedroom A was not interconnected. HM-B removed this smoke alarm from the bracket and stated the batteries were missing. HM-B installed new batteries into the smoke alarm and retested the wireless smoke alarm system. The smoke alarm in bedroom A was actuated and tested as interconnected while the surveyor was still onsite.

- HM-B stated wireless interconnected smoke alarms were installed to meet the statute requirements. When HM-B tested the wireless smoke alarm system, there were several extra battery operated smoke alarms installed in the building that were not actuated. HM-B stated these extra battery operated smoke alarms were pre-existing and would be removed as they were not part of the new wireless interconnected system. All dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The portable fire extinguisher in the kitchen cabinet was not mounted on a bracket. Fire extinguishers shall be properly installed to prevent them from being moved or damaged.

2. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies. [Minn. Stat. 144G.45 subd.2]

Comments: There was a 1-A:10-B:C portable fire extinguisher installed on the wall in the laundry/mechanical room. This fire extinguisher did not meet the minimum rating requirement.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- One side of the closet was off the track in occupied resident room D.
- When the exterior fence gate was opened, the bottom of the gate was dragging on the ground, making it difficult to operate.
- Above the back door, the ceiling beam had been patched, and this surface was unfinished. House manager (HM)-B stated they did not know why the beam had been repaired.
- The storm door was missing from the back door. House manager (HM)-B stated this door had been removed as it was damaged by the wind.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The emergency evacuation floor plans displayed in the building identified bedroom D in the basement. The letter D was not posted on or at the door for this occupied resident bedroom. Resident room identifiers are required to be posted at the doors and correspond with the evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.

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

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site 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 exit doors and egress windows were not identified on the emergency evacuation floor plans displayed in the building.*
- *The surveyor requested a copy of the fire safety and evacuation plan from house manager (HM)-B. HM-B stated it was posted on the wall by the back exit door. These FSEP employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. HM-B explained that additional FSEP employee procedures were included with the fire evacuation staff training documentation.*
- *The provided hazard analysis for fire inappropriately instructed employees to generally plan to shelter in place and wait for the fire department to order evacuation in a building without fire resistant construction and life safety systems.*

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

Comments: The licensee failed to develop site specific fire safety and evacuation instructions for residents evident by the lack of these procedures in the plan.

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

Comments: The fire safety and evacuation plan failed to include evacuation procedures for the individualized unique needs of residents. These procedures were included in the fire evacuation staff training documentation. These individualized resident procedures would not be easily accessible to staff or emergency responders during a fire or similar emergency.

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

Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the last year from the licensee. Record review of the provided documentation indicated employees completed FSEP training on April 24, 2026. Documentation was not provided to support employee training on the FSEP was completed at the required frequency of twice per year. Additionally, the FSEP training acknowledgement checklist included inaccurate building information, pull stations, alarm panels, and smoke compartments were referenced.

6. 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: The surveyor requested records for evacuation drills completed in the past year from house manager (HM)-B. Record review of the provided fire drill logs indicated no drills had been completed in 2026 and two fire drills were recorded in 2025. The licensee failed to meet the evacuation drill frequency. Additionally, the fire drill logs lacked simulated fire locations and drill conditions.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

Comments:

- *There was an active construction project in the basement. House manager (HM)-B stated there had been water damage and the licensee was in the process of making repairs. The surveyor requested a copy of the local building permit for this project and HM-B stated they did not know if a permit was obtained. A building permit was not provided by the licensee for review when requested.*
- *Additionally, the licensee failed to submit a plan review application to Minnesota Department of Health Engineering Services for the basement construction project.*
- *An exterior ramp was installed on the back deck. The licensee indicated the ramp was pre-existing when they took over the business in 2023 and they did not know when it was installed. The surveyor contacted the city for assistance. The city responded there was no record of a permit on file for this ramp.*