



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 11, 2026

Licensee

THE JAMES INC

4533 Normandale Highlands Drive

Bloomington, MN 55437

RE: Project Number SL30485016

Dear Licensee:

On January 29, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 16, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 16, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 16, 2025, found not corrected at the time of the January 29, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on January 29, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on January 29, 2026, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$1,000.00

1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

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

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/29/2026
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30485016-2 On January 28, 2026, through January 29, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 16, 2025, and December 15, 2025. At the time of the survey, there were five residents, all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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=I	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

Minnesota Department of Health

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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 provide sufficient documentation of actions taken to comply with the correction orders from a survey completed September 16, 2025, and follow up survey completed on December 15, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 340			

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0 340	Continued From page 2 or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the survey completed on September 16, 2025, after issuance of the immediate order 2310 related to bed rails, the licensee replied to the survey supervisor with documentation of their actions taken to comply with the immediate order of correction. The licensee's documented actions, however, did not meet the minimum requirements to maintain compliance. On September 17, 2025, at 3:30 p.m., the survey supervisor responded to the licensee and provided the licensee with resources to reference and education to assist them with achievement of compliance. On October 30, 2025, the licensee received results from the initial survey which concluded on September 16, 2025. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was November 20, 2024. The licensee's correction orders included tag identifier 2310 related to 144G.91 Subd. 4. (a) Appropriate care and services. On December 30, 2025, the licensee received results from a follow up survey which concluded on December 15, 2025. There was no time period of correction included as the re-issued orders were given a time period of correction following the first survey. The licensee's re-issued correction orders included tag identifier 2310	0 340			

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0 340	Continued From page 3 related to 144G.91 Subd. 4. (a) Appropriate care and services. On January 28, 2026, the surveyor requested the licensee's plan of correction (documentation of actions taken to comply with correction orders) via email at 11:02 a.m., and 3:34 p.m. In addition, the surveyor requested the plan of correction via phone at 11:00 a.m., and 2:35 p.m. On January 29, 2026, the surveyor requested the licensee's plan of correction via email at 6:23 a.m., and 8:02 a.m. On January 29, 2026, at 8:03 a.m., via phone, the surveyor inquired how the licensee corrected their orders issued on the previous survey. Licensed assisted living director/registered nurse (LALD/RN)-B stated they made corrections to the orders issued and stated they sent the plan of correction to the previous surveyor, and they had a plan. The surveyor again requested them to send the written plan of correction. On January 29, 2026, at 9:38 a.m., the surveyor received the licensee's plan of correction. The licensee's plan of correction titled Response to Minnesota Department of Health signed November 7, 2025, did not include information for tag identifier 2310. During the second follow up survey initiated on January 28, 2026, and exited on January 29, 2026, areas of deficient practice related to tag 2310 were identified and the correction order was again re-issued. No further information was provided.	0 340			

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0 340	Continued From page 4	0 340			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
			Not reviewed during this survey.		

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{0 480}	Continued From page 5	{0 480}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}			

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{0 480}	Continued From page 6 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 490} SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the	{0 490}			

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{0 490}	Continued From page 7 community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by:	{0 490}	Not reviewed during this survey.		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at	{0 570}			

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{0 570}	Continued From page 8 the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			

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{0 680}	Continued From page 9	{0 680}	Not reviewed during this survey.		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}			

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{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's	{01060}			

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{01060}	Continued From page 11 refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	{01330}			
{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	{01500}			

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

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{01500}	Continued From page 13 (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:	{01500}	Not reviewed during this survey.		
{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),	{01530}			

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{01530}	Continued From page 14 and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	01640	Not reviewed during this survey.		

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01640	Continued From page 15 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for three of three residents (R2, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on April 28, 2013, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing	01640			

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01640	Continued From page 16 statutes under Chapter144G. R2's diagnosis included quadriplegia. R2's Individual Abuse Prevention/Service Plan dated October 29, 2025, indicated R2 received assistance with behavior management, medication administration, toileting, social activities, housekeeping, laundry, range of motion, dressing, catheterization, and transfers. R3 R3 was admitted to the licensee on August 26, 2016, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R3's diagnosis included antisocial personality disorder. R3's Individual Abuse Prevention Plan Assessment dated October 27, 2025, indicated R3 received assistance with appointments, ambulation, behavior management, and toileting. R5 R5 was admitted to the licensee on April 14, 2013, and began receiving assisted living service on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R5's diagnoses included cardiovascular accident (CVA) and left sided hemiplegia. R5's Individual Abuse Prevention Assessment / Plan of Care dated July 11, 2025, indicated R5 received assistance with housekeeping, laundry, activities, shopping, medication administration, bathing, dressing, grooming, ambulation,	01640			

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01640	Continued From page 17 wheelchair mobility, transfers, behavior management, appointments, and meals. R2, R3, and R5's documents listed above lacked authentication by the resident, or their representative, documenting agreement on the services to be provided. On January 28, 2026, at 3:17 p.m., via email, the surveyor re-requested R5's service plan because the surveyor received an attachment labeled service plan from licensed assisted living director/registered nurse (LALD/RN)-B however, the surveyor believed the document was R5's individual abuse prevention plan, not a service plan. On January 28, 2026, at 3:28 p.m., via email, LALD/RN-B wrote, "Abuse prevention is also our service plan." On January 29, 2026, at 8:03 a.m., LALD/RN-B verbally confirmed the documents listed above were R2, R3, and R5's service plans. LALD/RN-B stated they were not aware the service plan needed to be signed by the residents because the form the licensee used did not include a resident signature line. The licensee's Service Plan policy dated November 10, 2025, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640			

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01640	Continued From page 18 (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency 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 interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents	01650			

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01650	Continued From page 19 (R2, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on April 28, 2013, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under Chapter144G. R2's diagnosis included quadriplegia. R2's Individual Abuse Prevention/Service Plan dated October 29, 2025, indicated R2 received assistance with behavior management, medication administration, toileting, social activities, housekeeping, laundry, range of motion, dressing, catheterization, and transfers. R3 R3 was admitted to the licensee on August 26, 2016, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R3's diagnosis included antisocial personality disorder.	01650			

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01650	Continued From page 20 R3's Individual Abuse Prevention Plan Assessment dated October 27, 2025, indicated R3 received assistance with appointments, ambulation, behavior management, and toileting. R5 R5 was admitted to the licensee on April 14, 2013, and began receiving assisted living service on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R5's diagnoses included cardiovascular accident (CVA) and left sided hemiplegia. R5's Individual Abuse Prevention Assessment / Plan of Care dated July 11, 2025, indicated R5 received assistance with housekeeping, laundry, activities, shopping, medication administration, bathing, dressing, grooming, ambulation, wheelchair mobility, transfers, behavior management, appointments, and meals. R2, R3, and R5's documents listed above lacked the following required content: - fee's for service; - frequency of each service; - identification of staff or categories of staff who would provide the service; - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring staff providing services; A contingency plan that included: - the action to be taken if the scheduled service cannot be provided - information 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	01650			

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01650	Continued From page 21 change in the resident's condition, including identification resident about changes to facility's fee for service and how to contact the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities. On January 28, 2026, at 3:17 p.m., via email, the surveyor re-requested R5's service plan because the surveyor received an attachment labeled service plan from licensed assisted living director/registered nurse (LALD/RN)-B however, the surveyor believed the document was R5's individual abuse prevention form. On January 28, 2026, at 3:28 p.m., via email, LALD-B wrote, "Abuse prevention is also our service plan." On January 29, 2026, at 8:03 a.m., LALD/RN-B verbally confirmed the documents listed above were R2, R3, and R5's service plans. LALD/RN-B stated after the last Minnesota Department of Health (MDH) survey the licensee changed their service plan form. LALD/RN-B stated the previous surveyor told them more detailed information was needed related to services being received by the residents. LALD/RN-B stated the licensee then changed to a different form and did not bring over all the service plan content the previous form contained. LALD/RN-B stated they attempted to improve their service plan after the last survey, however, due to a lack of understanding the service plan was still missing some of the required content. The licensee's Service Plan policy dated November 10, 2025, indicated a service plan would include: - a description of the services that are to be	01650			

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01650	Continued From page 22 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 would be providing services; - a schedule and method for the next planned assessment or monitoring; - a schedule and method for the next planned monitoring of staff providing services; and - a contingency plan that included: - actions the licensee would take if scheduled services could not be provided; - information regarding how the resident can contact the 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 residents condition; and - identification and contact information of who the resident has authorized if any to sign for the resident in an emergency - how the licensee would support documented 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			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	{01760}			

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{01760}	Continued From page 23 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}	Not reviewed during this survey.		
{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:	{01820}			
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced	{01830}			

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{01830}	Continued From page 24 by:	{01830}	Not reviewed during this survey.		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	{02310}	Not reviewed during this survey.		

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{02310}	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, and medical, or nursing standards for three of three residents (R2, R3, R5) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a previous survey on September 15, 2025, at 11:06 a.m., the surveyor observed hospital beds in the rooms of R2, R3, and R5. R2's hospital bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. Both bed rails at the head of the bed were in the raised position. The bed rails at the foot of the bed were in the low position. R3's bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. The upper right bed rail was in the raised position and was pressed up against the wall of the bedroom. The other three bed rails on R3's bed were in the low position. R5's bed had two bed rails installed bilaterally at the head of the bed. The upper left bed rail was in the raised position and pressed up against the wall of the bedroom. The other bed rail on R5's bed was in the low position.	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/29/2026
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437		
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{02310}	Continued From page 26 On September 16, 2025, at 3:30 p.m., the licensee received an immediate order for correction, tag identification number 2310, related to non-compliant bed rail assessments. The correction order 2310 related to bed rails was also re-issued after a follow up survey that concluded on December 15, 2025. R2 R2 was admitted to the licensee on April 28, 2013, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under Chapter144G. R2's diagnosis included quadriplegia. R2's service plan dated October 29, 2025, indicated R2 received assistance with behavior management, medication administration, toileting, social activities, housekeeping, laundry, range of motion, dressing, catheterization, and transfers. In addition, the service plan indicated bed rail assessment was in place, bed rail agreement was in place, safety checks of bed rail every shift when in use, and staff were to report concerns with bed rails to the nurse promptly. R2's assessment titled, [the licensee's name] Side Rails RN Assessment, showed the Food and Drug Administration's (FDA) guidance on bed rails and was attached to a document titled, Staff Education Signed in Log Topic Bed Siderails Assessment every 90 days by RN. The document included clinical nurse supervisor (CNS)-A's printed name and signature next to the date of September 24, 2025, and licensed assisted living director/registered nurse (LALD/RN)-B's printed name and signature next to the date of December 24, 2025. The document had no further	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 27 information written on it. R2's progress note dated September 24, 2025, read, "Side rail Assessment in bed: Resident made aware of the risk and benefit as well with his family. Resident said he want [sic] the side rail in his bed for positioning and transfer. Bed rail measurement room #2 Mattress to top of the side rail is measuring 4 ½ inches then between side rail and headboard measured 3 2/4 inches to prevent entrapment. Nurse to continue with S/R [side rail] Assessment q [every] 90 days." R3 R3 was admitted to the licensee on August 26, 2016, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R3's diagnosis included antisocial personality disorder. R3's service plan dated October 27, 2025, indicated R3 received assistance with appointments, ambulation, behavior management, and toileting. R3's service plan indicated R3 did not have bed rails. R3's assessment titled, [the licensee's name] Side Rails RN Assessment, showed the Food and Drug Administration's (FDA) guidance on bed rails and was attached to a document titled, Staff Education Signed in Log Topic Bed Siderails Assessment every 90 days by RN. The document included CNS-A's printed name and signature next to the date of September 24, 2025, and LALD/RN-B's printed name and signature next to the date of December 24, 2025. The document had no further information written on it.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 28 R3's progress note dated September 24, 2025, read, "Siderail Assessment done, resident Made aware of the risk and benefit, family also made aware But [sic] resident insisted to have the ed siderail to assist in positioning in bed. Bed rail measurement room #3 Mattress to top of the S/R is measuring 4 ½ inches, between siderail and headboard measured 3 ¾ inch to prevent entrapment. The nurse to do the bed rail assessment every 90 days". R5 R5 was admitted to the licensee on April 14, 2013, and began receiving assisted living service on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R5's diagnoses included cardiovascular accident (CVA) and left sided hemiplegia. R5's service plan dated July 11, 2025, indicated R5 received assistance with housekeeping, laundry, activities, shopping, medication administration, bathing, dressing, grooming, ambulation, wheelchair mobility, transfers, behavior management, appointments, and meals. R5's service plan did not address bed rails. R5's assessment titled, [the licensee's name] Side Rails RN Assessment, showed the Food and Drug Administration's (FDA) guidance on bed rails and was attached to a document titled, Staff Education Signed in Log Topic Bed Siderails Assessment every 90 days by RN. The document included CNS-A's printed name and signature next to the date of September 24, 2025, and LALD/RN-B's printed name and signature next to the date of December 24, 2025. The document had no further information written on it.	{02310}			

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{02310}	Continued From page 29 R5's progress note dated September 24, 2025, read, "Bed rail Assessment: Done. Resident made aware of the risk and benefit, including resident family, but resident continue [sic] to want the use of bed siderail for positioning in bed and assist with transfer. Bedrail measurement room #5 mattress to top of the S/R is measuring 4 ½ inches then b/w [between] S/R and headboard measure 3 ¾ inches to prevent entrapment. Nurse to measure q 90 days." R2, R3, and R5's records lacked documentation of: - a bed rail assessment which included: - the type of bed rail being assessed; - the resident's preferences; - the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person was at high risk for entrapment; - whether the bed rail has the effect of being an improper restraint; - if the bed rail was securely attached to the bed frame per manufacturer's recommendations; - and - measurements of the bed rail and documentation to show the bed rails were FDA compliant. On January 29, 2026, at approximately 8:03 a.m., the surveyor inquired what bed rail zones were being measured in the assessment. LALD/RN-B stated they believed the measurements in the assessment were zones one and two. LALD/RN-B stated the other zones were measured but were not documented because there was not a large enough gap to have the risk of entrapment. LALD/RN-B stated they completed bed rail assessments according to FDA	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 30 standards. LALD/RN-B stated they took the measurements and made sure the bed rails were attached correctly. LALD/RN-B stated the documents titled "[the licensee's name] Side Rails RN Assessment" and "Staff Education Signed in Log Topic Bed Siderails Assessment" was where the nurses documented they conducted the bed rail assessment. LALD/RN-B stated the licensee did not document all of the bed rail zones measured or all of the things they assessed during their bed rail assessment. On January 29, 2026, at 10:25 a.m., via email, LALD/RN-B confirmed R2, R3, and R5's bed rails had not changed since the initial survey. During the survey concluded on September 16, 2025, after issuance of the immediate order 2310 related to bed rails, the licensee replied to the survey supervisor with documentation of their actions taken to comply with the immediate order of correction. The licensee's documented actions, however, did not meet the minimum requirements to maintain compliance related to bed rail assessments. On September 17, 2025, at 3:30 p.m., the survey supervisor responded to the licensee and provided the licensee with resources to reference and education to assist them with achievement of compliance. The Licensee's Side Rails policy dated June 2, 2025, indicated when the licensee is aware of a resident utilizing side rails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions.	{02310}			

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{02310}	Continued From page 31 The FDA document titled A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts dated December 11, 2017, read, "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." In addition, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 13, 2025, read, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, it included, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences	{02310}			

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{02310}	Continued From page 32 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). https://bookshelf.vitalsource.com/books/9780443245336 Unit 4. Professional Standards in Nursing Practice Section 26. Informatics and documentation, page 391, indicated, "It is necessary to document all the nursing care you provide for each patient, including assessment data, nursing problems or diagnoses, interventions, and evaluation of patient responses, in the health record. Your data enable providers and outside reviewers of the health record to track a patient's clinical course." No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 30, 2025

Licensee

The James Inc

4533 Normandale Highlands Drive

Bloomington, MN 55437

RE: Project Number(s) SL30485016

Dear Licensee:

On December 15, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 16, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 16, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 16, 2025, found not corrected at the time of the December 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on December 15, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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:

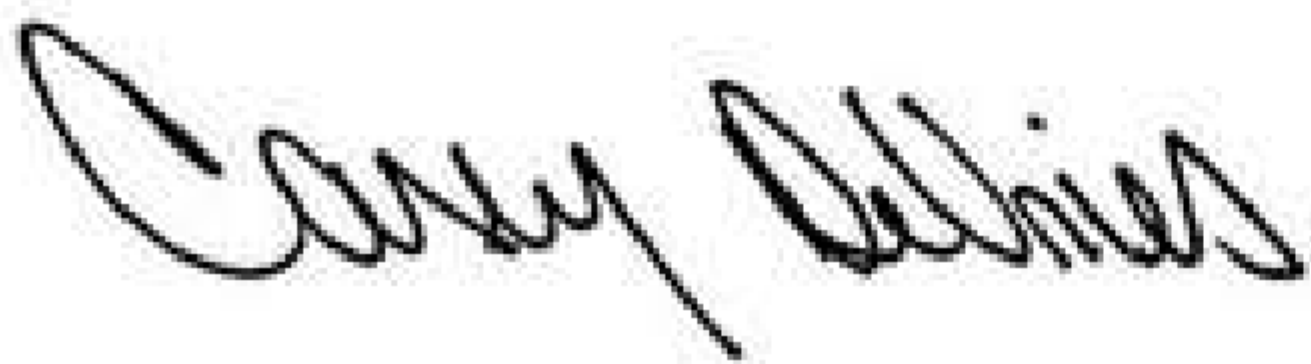
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/15/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30485016-1 On December 15, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 17, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey		

Minnesota Department of Health

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{0 480}	Continued From page 2 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 3 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey		
{0 490} SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental,	{0 490}			

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{0 490}	Continued From page 4 and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by:	{0 490}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey		
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey		
			Not reviewed during this survey		

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{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms	{0 900}	Not reviewed during this survey		

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{0 900}	Continued From page 6 concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	{01060}	Not reviewed during this survey		

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{01060}	Continued From page 7 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey		

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{01060}	Continued From page 8	{01060}			
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	{01330}			
{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	{01500}	Not reviewed during this survey		

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{01500}	Continued From page 9 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following 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	{01500}			

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{01500}	Continued From page 10 (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:	{01500}	Not reviewed during this survey		
{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	{01530}			

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{01530}	Continued From page 11 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}			

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{01760}	Continued From page 12 by:	{01760}	Not reviewed during this survey		
{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:	{01820}	Not reviewed during this survey		
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by:	{01830}	Not reviewed during this survey		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	{01910}	Not reviewed during this survey		

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{01910}	Continued From page 13 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, and medical, or nursing standards for three of three residents (R2, R3, R5) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was	{02310}			

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{02310}	Continued From page 14 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 September 15, 2025, at 11:06 a.m., during a tour of the facility, the surveyor observed hospital beds in the rooms of R2, R3, and R5. R2's hospital bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. Both bed rails at the head of the bed were in the raised position. The bed rails at the foot of the bed were in the low position. R3's bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. The upper right bed rail was in the raised position and was pressed up against the wall of the bedroom. The other three bed rails on R3's bed were in the low position. R5's bed had two bed rails installed bilaterally at the head of the bed. The upper left bed rail was in the raised position and pressed up against the wall of the bedroom. The other bed rail on R5's bed was in the low position. R2 R2 was admitted to the licensee on April 13, 2013, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under Chapter144G. R2's diagnoses included quadriplegia. R2's service plan dated October 29, 2015, indicated R2 received assisted living services to include medication setup and administration, transfer board assistance, positioning, therapeutic exercise, socialization, catheter care, bathing	{02310}			

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{02310}	Continued From page 15 assistance, grooming, shopping assistance, and laundry. R3 R3 was admitted to the licensee on August 26, 2016, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under Chapter 144G. R3's diagnoses included antisocial personality disorder. R3's record lacked documentation of a service plan. On September 16, 2025, at 8:11 a.m., the surveyor observed clinical nurse supervisor (CNS)-A prepare and administer medications to R3. R5 R5 was admitted to the licensee on April 14, 2013, and began receiving assisted living service on August 1, 2021, with the implementation of Assisted Living licensing statutes under Chapter 144G. R5's diagnoses included Cardiovascular accident (CVA) and left sided hemiplegia. R5's service plan dated March 21, 2021, indicated R5 received assisted living services to include assistance with dressing, assistance with meals, oral hygiene, hair care, grooming, toileting assistance, assistance with bathing, stand by assistance, medication reminders, medication administration, hands on assistance with mobility transfers, housekeeping, laundry, behavior management, assistance with appointments, and	{02310}			

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{02310}	Continued From page 16 socialization. R2, R3, and R5's records lacked documentation of: - purpose and intention of the bed rail; - measurements of the bed rail; - the resident's bed rail use/need assessment; - the resident's preferences; - physical inspection of bed rail(s) and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; - documentation to show the bed rails were FDA compliant, and; - documentation of the risk vs. benefits being discussed and documented with the resident/responsible party. On September 16, 2025, at 2:06 p.m., during the full survey, CNS-A stated they had completed training with staff on bed rail safety. CNS-A then asked if training completed with staff was enough. CNS-A stated no physical assessments had been completed for bed rails and they were not aware of the requirement. On December 16, 2025, at 12:06 p.m., during a licensing order follow up survey, licensed assisted living director (LALD)-B provided a copy of a form via email, used to document the assessment of R2, R3, and R5's bed rails. The form was an informational sheet that described the required information to be included in a bed rail assessment and at the bottom of the sheet was a signature page which contained the signature of CNS-A dated September 24, 2025. The form lacked the following required content of the bed rail assessment:	{02310}			

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{02310}	Continued From page 17 - purpose and intention of the bed rail; - measurement specific to bedrail; - an assessment of the resident's use/need assessment; - risk vs benefits discussion individualized to each resident's risks; - documentation of the residents' preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation, and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On December 16, 2025, at 1:01 p.m., LALD-B stated the form was provided in their policy and procedure manual, and was what the licensee used to document a bed rail assessment. LALD-B stated there was no further documentation for bed rail assessments. The Licensee's undated 6.28 Side Rails policy, indicated when the licensee is aware of a resident utilizing side rails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/15/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437		
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{02310}	Continued From page 18 be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 30, 2025

Licensee

The James Inc.

4533 Normandale Highlands Drive

Bloomington, MN 55437

RE: Project Number(s) SL30485016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 16, 2025, 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:

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEpHVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437			
(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: SL30485016-0 On September 15, 2025, through September 16, 2025, 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 five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 470	Continued From page 2 Minnesota Administrative Rule 4659.0180, accessible to staff, residents, volunteers, and the public as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 September 15, 2025, at 11:06 a.m., during a tour of the facility, clinical nurse supervisor (CNS)-A pointed out the licensee's posted employee schedule. The licensee's posted employee schedule was a blue plastic clipboard which had the name of staff working for the day as well as the date written on it using dry erase marker. CNS-A explained when staff came on shift for the day, they updated the name and date on the clipboard. CNS-A stated there was no other posted schedule. On September 17, 2025, at 1:08 p.m., licensed assisted living director (LALD)-B stated the licensee completed a review of the licensee's staffing plan on an annual basis. On September 17, 2025, at 12:04 p.m., the surveyor observed the clipboard utilized as the licensee's posted employee schedule. The surveyor observed the licensee's board had not been updated for the day, showing a date of	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 September 16, 2025, and the name of the staff member who had worked the previous evening. The licensee's undated 4.06 Staffing & Scheduling policy indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;	0 490			

Minnesota Department of Health

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0 490	Continued From page 6 (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, which create opportunities for active participation in the community at large. This had the potential to affect all five residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 11:06 a.m., during a	0 490			

Minnesota Department of Health

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0 490	Continued From page 7 facility tour, the surveyor observed a posting board which was secured behind a locked glass cabinet. The posting board lacked documentation of an activity schedule. On September 17, 2025, licensed assisted living director (LALD)-A stated they thought there used to be a posted activity schedule, but it was taken down when the facility repainted, and was not reposted. The licensee's undated 1.34 Activity Programming policy indicated a monthly activity calendar will be created and available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 510			

Minnesota Department of Health

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0 510	Continued From page 8 Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving, hand hygiene, and catheter care for one of two employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 September 16, 2025, at 7:47 a.m., while verifying medications for a resident, the surveyor observed CNS-A bump the medication cup which contained the morning medication for R5, and caused pills to slide across the countertop. The surveyor then observed CNS-A pick up the spilled medications and put them back into the medication cup for administration. The surveyor observed CNS-A administer R5's morning medications at 7:52 a.m. The surveyor did not observe CNS-A clean the countertop prior to set up of medications. The countertop was visibly soiled with multiple spots which appeared to be dried food. On September 15, 2025, at 10 :51 a.m., during the entrance conference, CNS-A stated in the	0 510			

Minnesota Department of Health

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0 510	Continued From page 9 event of a medication being dropped during preparation or administration, the expectation would be for that medication to be disposed of, and a new medication administered to the resident. On September 17, 2025, at 1:13 p.m., licensed assisted living director (LALD)-B stated they were surprised the countertop was not cleaned prior, and the medications should have been disposed of instead of being administered. The licensee's undated 8.05 Disinfecting Environmental Surfaces policy indicated that high touch areas such as telephones, handrails and door handles/knobs, counter tops, TV remotes and computer keyboards should be kept clean and free from contamination. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance as required. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 570			

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NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437			
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0 570	Continued From page 10 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 11:06 a.m., during a facility tour the surveyor observed the licensee's previous years license posted in a frame near the entrance of the facility. The surveyor was unable to locate the licensee's current license. On September 17, 2025, at 1:14 p.m., licensed assisted living director (LALD)-B stated they thought they had posted the current license and were unaware the current license was not posted. The licensees' undated 2.04 Assisted Living License and Posting policy indicated the licensee would maintain a current Assisted Living Licensure issued by the Minnesota Department of Health which would be posted at the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
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	0 680			

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0 680	Continued From page 11 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 12 The findings include: On September 15, 2025, at 1:05 p.m., the surveyor requested the licensee's EPP. Clinical nurse supervisor (CNS)-A stated they were aware the EPP needed to be posted within the facility, but for some reason it was left in the licensees off campus office. On September 15, 2025, at 2:03 p.m., licensed assisted living director (LALD)-B arrived at the facility with the licensee's EPP. LALD-B stated the provided EPP was up to date and complete in its content and was at the licensee's off-campus office being updated, acknowledging there was no complete EPP on site while the EPP was being updated off-site. The licensee's undated EPP lacked evidence of the following required content: - A policy and procedure for tracking the location of on-duty staff and sheltered residents; - A policy and procedure to sheltering in place; - Copies of arrangements with other facilities, and; - Emergency official contact information. The licensee's undated 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy indicated the licensee would have a plan in place that would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided.	0 680			

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0 680	Continued From page 13	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 provide facilities that were not a distinct hazard to life and comply with the Minnesota State Fire Code. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on September 16, 2025, between 10:30 a.m. and 12:30 p.m. with clinical nurse supervisor (CNS)-A and later with licensed assisted living director (LALD)-B, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms. Upper-level resident sleeping room 1 emergency	0 775			

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0 775	Continued From page 14 escape and rescue clear window opening measurements are W19" X H39" X SH37", this window does not meet the 20" minimum opening. This is an unoccupied room. Upper-level resident room 5 emergency escape and rescue clear opening measurements are W20" X H30" X S36". (600 square inch opening) This window does not meet the 648 square inch total. This is an occupied room. The windows were measured by the surveyor with the CNS-A present. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by CNS-A and later LALD-B accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. Additionally on facility tour on September 16, 2025, between 10:30 a.m. and 12:30 p.m. with clinical nurse supervisor (CNS)-A and later with the licensed assisted living director (LALD)-B the surveyor observed the following conditions:	0 775			

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0 775	Continued From page 15 GARAGE SEPARATION: The surveyor observed a window in the door between the garage and the facility. The separation between the garage and the facility shall be maintained. OXYGEN CYLINDERS STORAGE: The surveyor observed that there were two oxygen cylinders in the garage that were not secured and partially leaning over. All oxygen cylinders shall be secured to prevent them from falling over and being damaged. LOCK: The surveyor observed a slide bolt lock n the swing gate at the top of the steps. This lock shall be removed. ELECTRICAL: The surveyor observed weatherproof covers missing on two electrical receptacles on the deck. The covers shall be fixed. Also, the light in the office in the lower level needs to be fixed. The bulb is hanging down through the ceiling tile. CARBON MONOXIDE:	0 775			

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0 775	Continued From page 16 The surveyor observed the carbon monoxide alarm in the lower level had expired. The deficient conditions were visually verified by CNS-A and LALD-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 800			

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0 800	Continued From page 17 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On facility tour on September 16, 2025, between 10:30 a.m. and 12:30 p.m. with clinical nurse supervisor (CNS)-A and later with the licensed assisted living director (LALD)-B the surveyor observed the following conditions: ROTTEN DECK BOARDS: The surveyor observed rotten boards on the deck and on the steps off the deck. The rotten boards shall be replaced. HOLE IN FLOORING: The surveyor observed a hole in the flooring in the upper-level hallway that was filled with appeared to be caulk. This hole was large enough to cause a trip hazard. The deficient conditions were visually verified by O/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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:	0 810			

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0 810	Continued From page 18 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety evacuation training for the employees and residents and the fire safety evacuation plan was missing several required items. This had the	0 810			

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0 810	Continued From page 19 potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: A record review and interview were conducted on September 16, 2025, at approximately 12:00 p.m. with clinical nurse supervisor (CNS)-A and with licensed assisted living director (LALD)-B on the fire safety and evacuation plan, training records and fire drills. TRAINING: Training for the employees and residents on the fire safety and evacuation plan was not being conducted. This shall be completed at new hire and twice a year thereafter for employees and at intake and once a year thereafter for residents. This shall be documented. FIRE SAFETY EVACUATION PLAN: The fire safety evacuation plan did not have a meeting place outside the facility identified.	0 810			

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0 810	Continued From page 20 The lower level did not have an evacuation plan posted. Some resident room doors were not labeled. The LALD-B could not provide a signed memorandum of understanding for the location they planned to move residents to in case of evacuation. The deficiencies noted above were verified by the CNS-A and LALD-B TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900			

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0 900	Continued From page 21 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content upon implementation of Assisted Living Licensure for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted April 28, 2013, and began receiving assisted living services on August 1, 2021. R2's record contained an undated contract which lacked a signature. On September 17, 2025, at 1:02 p.m., licensed	0 900			

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0 900	Continued From page 22 assisted living director (LALD)-B stated they were unaware R2's record lacked a signed contract and that it must have been overlooked. The licensee's undated 1.05 Signing an Assisted Living Contract policy indicated when a prospective resident decides to move into licensee's facility, a signed Assisted Living Contract would be received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060			

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01060	Continued From page 23 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of four residents (R5). 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	01060			

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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
01060	Continued From page 24 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: R5 was admitted to the licensee on April 14, 2013, and began receiving assisted living service on August 1, 2021. R5's diagnosis included cardiovascular accident (stroke) and left sided hemiplegia (paralysis on one side of the body). R5's service plan dated March 21, 2021, indicated R5's received assisted living services to include dressing, meals, oral hygiene, hair care, grooming, toileting , bathing, stand by assistance, medication reminders, medication administration, hands on assistance with mobility transfers, housekeeping, laundry, behavior management, assistance with appointments, and socialization. R5's record contained a progress note dated April 13, 2025, which indicated they had been emergently transferred to the hospital via ambulance due to stroke-like symptoms. R5's record contained another progress note indicating a readmission to the licensee occurred on July 8, 2025, which indicated R5 had been out of the facility due to an emergency relocation for 86 days. On September 15, 2025, at 1:19 p.m., clinical nurse supervisor (CNS)-A stated R5 had been sent to the hospital due to stroke symptoms and was then discharged from the hospital to a transitional care unit prior to being readmitted to the licensee. CNS-A stated they were unaware of	01060			

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01060	Continued From page 25 the need for the emergency relocation notice and asked if it was new requirement. The surveyor provided information for how to complete the emergency relocation and where to locate forms if needed. The licensee's undated 1.23 Emergency Relocation policy indicated the licensee would provide a written notice that contains at a minimum the reason for the relocation, the name and contact information for the location to which the resident has been relocated and any new service provider, contact information for the Office of Ombudsman for Long-Term Care, if known the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. Additionally, this notice would be delivered as soon as possible to the resident, legal representative, and designated representative, the resident's case manager, and the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully	01330			

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01330	Continued From page 26 completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired June 22, 2016, and began providing assisted living services on August 1,	01330			

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01330	Continued From page 27 2021. The surveyor observed ULP-C provide assisted living services on September 15, 2025, from 11:31 a.m. to 12:32 p.m. ULP-C's record lacked documentation of training and competency evaluations in the following areas: - care and use of hearing aids; - preparation of modified diets as ordered by a licensed health professional. On September 17, 2025, at 12:42 p.m., licensed assisted living director (LALD)-B stated the licensee was not currently providing the types of services for residents mentioned above and was unaware staff were required to be trained on the topics. LALD-B stated all other unlicensed personnel would lack the training as well. The licensee's undated 5.02 competency Training Evaluations policy indicated training and competency evaluations for all ULPs will include care and use of hearing aids and preparation of modified diets as ordered by a licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
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	01500			

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

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01500	Continued From page 29 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 annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: CNS-A CNS-A was hired on September 25, 2006, and began providing clinical oversight and assisted living services on August 1, 2021.	01500			

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01500	Continued From page 30 CNS-A's employee record contained documentation of orientation having taken place on August 25, 2021. CNS-A's employee records lacked documentation of any additional trainings. ULP-C ULP-C was hired June 22, 2016, and began providing assisted living services on August 1, 2021. The surveyor observed ULP-C providing assisted living services on September 15, 2025, from 11:31 a.m. to 12:32 p.m. ULP-C's employee record contained a document titled Annual Employee Training dated October 11, 2024. The document indicated ULP-C completed training in the required 22 areas of 144A.4795, Subd. 7(b) and (c). The document lacked documentation of the required annual trainings per 144G.63, subd. 5. On September 17, 2025, at 12:36 p.m., licensed assisted living director (LALD)-B stated "CNS-A is a registered nurse, so they are not required to complete the annual CNA training." Additionally, LALD-B stated all other staff's records would contain the same annual trainings as ULP-C. The licensee's undated 5.06 Annual Required Staff Training policy indicated the following: "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights	01500			

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01500	Continued From page 31 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment: disinfecting environmental surfaces: and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." 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	01530			

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01530	Continued From page 32 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the	01530			

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01530	Continued From page 33 first 120 hours for a supervisor of direct care staff and within 160 working hours of employment for direct care staff as required for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). Additionally, the licensee failed to ensure direct care staff complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: CNS-A CNS-A was hired on September 25, 2006, and began providing clinical oversight and assisted living services on August 1, 2021. CNS-A's employee record contained documentation of five separate modules for dementia care training dated August 17, 2021. The documentation did not indicate a number of hours or time for the completion of the dementia care training. CNS-A's employee record lacked any additional dementia care training as well as mental health training. ULP-C	01530			

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01530	Continued From page 34 ULP-C was hired June 22, 2016, and began providing assisted living services on August 1, 2021. The surveyor observed ULP-C providing assisted living services on September 15, 2025, from 11:31 a.m. to 12:32 p.m. ULP-C's employee record contained documentation of five separate modules for dementia care training dated October 11, 2021. The documentation did not indicate a number of hours or time for the completion of the dementia care training. ULP-C's employee record lacked any additional dementia care training as well as mental health training. On September 17, 2025, at 12:45 p.m., licensed assisted living director (LALD)-B stated the facility was not licensed as a dementia unit, but that they did still complete some dementia training. Additionally, LALD-B stated they were unaware of the new mental health training requirements and asked where the information could be found, and how they could make sure they were updated on future changes. The licensee's undated 5.03 Dementia Training indicated supervisors of direct care staff will complete eight hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of three residents (R5). 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: R5 was admitted to the licensee April 14, 2013, and began receiving assisted living services on August 1, 2021.	01760			

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01760	Continued From page 36 R5's diagnosis included cardiovascular accident (stroke) and left sided hemiplegia (paralysis on one side of the body). R5's service plan dated March 21, 2021, indicated R5 received assisted living services to include dressing, meals, oral hygiene, hair care, grooming, toileting, bathing, stand by assistance, medication reminders, medication administration, hands on assistance with mobility transfers, housekeeping, laundry, behavior management, assistance with appointments, and socialization. R5's signed After Visit Summary dated September 2, 2025, indicated R5's previously prescribed Eliquis was to be stopped. R5's paper medication administration record (MAR) dated September 1, 2025, to September 30, 2025, indicated Eliquis was scheduled to be administered twice daily at 8:00 a.m., and at HS (hour of sleep). The MAR contained an unsigned handwritten annotation that indicated the Eliquis 5 mg tab was to be stopped as of September 2, 2025. There were illegible initials in boxes for the HS dosing period for September 2-7, 2025, indicating the medication was administered for five days after the discontinuation order was received. The MAR contained no notes on the back to identify any abnormalities with the medication administration process. After September 7, 2025, a line was drawn through the boxes of the HS dosing period for the remainder of the days of the month. The MAR contained three crossway slash marks in the general area of the initial boxes to indicate the order was no longer in use, but did not contain any lines through the boxes for initialing the 8:00 a.m.,	01760			

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01760	Continued From page 37 dosing period as it did for the HS dosing period. On September 16, 2025, at 7:39 a.m., the surveyor observed clinical nurse supervisor (CNS)-B prepare morning medications for R5 using the MAR with a note to stop the Eliquis. Additionally, the surveyor observed that R5's comingled medication pouch, prepared by the pharmacy, listed Eliquis 5 milligram (mg) tab, but had been crossed out. The medication pouch listed the following medications: - Celexa 20mg tablet; - Acetaminophen 325mg, 2 tablets; - Certavite; - Risperdal 0.25mg tablet; and - Vitamin D3 1000unit. On September 16, 2025, at 7:44 a.m., the surveyor observed CNS-B open up R5's comingled medication pouch and dump the medications into a medication cup. The surveyor observed there was a total count of medications in the cup of seven pills. Using the medication identification spreadsheet printed at the top of the medication card that contained R5 comingled medication pouches, the surveyor was able to identify R5's discontinued Eliquis 5mg tablet. On September 16, 2025, at 7:46 a.m., the surveyor observed CNS-B complete their medication checks, at which point, the surveyor asked CNS-B if they were ready to administer R5's morning medications. CNS-B stated they were complete with their process and were going to go to R5's room for administration. The surveyor then stopped CNS-B and instructed CNS-B to recheck the morning medications. On September 16, 2025, at 7:49 a.m., CNS-B	01760			

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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
01760	Continued From page 38 verified R5's discontinued Eliquis was still in the medication cup. CNS-B stated they had removed R5's Eliquis from their previous medication doses but must have missed this dose. Although the licensee received a physician's order to discontinue a medication, the licensee failed to adequately document on the MAR and implement the physician's order. The MAR contained no explanations or follow-up procedures when the medication was administered despite the physician's order to discontinue. The licensee's undated 7.08 Medication Management - Administration & Setup indicated the licensee would ensure staff utilize the medications profile listing the medication name, dosage, date, and time administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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 licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2).	01820			

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01820	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on April 13, 2013, and began receiving assisted living service on August 1, 2021. R2's diagnosis included quadriplegia (a form of paralysis that affects all a person ' s limbs and body from the neck down). R2's service plan dated October 29, 2015, indicated R2 received assisted living services to include medication setup and administration, transfer board assistance, positioning, therapeutic exercise, socialization, catheter care, bathing, grooming, shopping assistance, and laundry. R2's record lacked documentation of signed physician orders. R2's medication administration record (MAR) for the month of September 2025, indicated R2 was receiving the following medications: - Dantrium 25 milligram (mg) capsules, take 2 capsules by mouth three times daily; - Bisacodyl 10mg suppository, unwrap and insert on suppository on Monday, Wednesday, and Friday;	01820			

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01820	Continued From page 40 - Cleocin-T 1% lotion, apply topically to the groin and armpits after showering; - Prilosec 40mg cr capsule, take 1 capsule by mouth daily; - Baclofen 20mg tablet, take 1&1/2 tablets by mouth four times a day; - Klonopin 0.5mg tablet, take 1 tablet by mouth twice a day; - Cymbalta 30mg capsule, take 1 capsule by mouth daily; - Oxybutynin 5mg tablet, take tablet by mouth three times a day, and; - Cymbalta 30mg capsule, take on capsule by mouth daily. On September 15, 2025, at 10:51 a.m., clinical nurse supervisor (CNS)-A stated orders are obtained in the form of after visit summaries or in faxes from the provider or pharmacy. On September 16, 2023, at 2:03 p.m., CNS-A stated they were unaware R2's record lacked documentation of signed physician orders. The licensee's undated 7.20 Medications & Treatment orders policy indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the	01830			

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01830	Continued From page 41 assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted August 26, 2016, and began receiving assisted living services August 1, 2021. R3's diagnosis included antisocial personality disorder. R3's service plan dated July 2, 2025, indicated R3 received assisted living services to include medication setup and administration, behavior management, toileting, shopping, assistance with grooming, laundry, and housekeeping. R3's record contained a signed clinical referral form dated May 26, 2023, which was signed in conjunction to an After-Visit Summary (AVS) dated May 26, 2023. R3's record lacked	01830			

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01830	Continued From page 42 additional signed orders. The AVS contained the following medications: - Lipitor 40 milligram (mg) tablet, take one tablet by mouth daily; - Wellbutrin XL 300mg tablet, take one tablet by mouth three times a day; - Vitamin D3 25 microgram (mcg) capsule, take one capsule by mouth daily; - Docusate sodium 100mg capsule, take one capsule by mouth twice a day; - Ibuprofen 600mg tablet, take one tablet by mouth three times a day as needed; - Acetaminophen 500mg tablet, take one tablet by mouth four times a day as needed; - Toprolol XL 25 mg, take one tablet by mouth daily; - Nyamyc 100mu/GM (unit per gram) powder, apply to affected areas topically twice a day as needed; - Prilosec 20mg capsule, take one capsule by mouth daily; - Risperidone 3mg tablet, take two tablets by mouth at bedtime; - Triamcinolone 0.1% ointment, apply thin layer to dry skin twice a day on shins for one week, then as needed for itching; R3's medications administration record (MAR) for the month of September 2025, indicated R3 was receiving the following medications: - Acetaminophen 500mg tablet, take one tablet by mouth four times a day as needed; - Lipitor 40mg tablet, take one tablet by mouth daily; - Toprolol XL 25 mg, take one tablet by mouth daily; - Vitamin D3 25mcg capsule, take one capsule by mouth daily; - Docusate sodium 100mg capsule, take one	01830			

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01830	Continued From page 43 capsule by mouth twice a day; - Prilosec 20mg capsule, take one capsule by mouth daily; - Triamcinolone 0.1% ointment, apply thin layer to dry skin twice a day on shins for one week, then as needed for itching; - Risperidone 3mg tablet, take two tablets by mouth at bedtime; - Wellbutrin XL 300mg tablet, take one tablet by mouth three times a day; - Nyamyc 100mu/GM powder, apply to affected areas topically twice a day as needed. On September 16, 2025, at 2:03 p.m., clinical nurse supervisor (CNS)-A stated they were not aware there were not up-to-date orders on file for R3. The licensee's undated 7.20 Medications & Treatment orders policy indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided	01910			

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01910	Continued From page 44 for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01910			

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01910	Continued From page 45 R1 was discharged from the licensee on May 1, 2025. R1's record lacked documentation of disposition of R1's medications. On September 15, 2025, at 10:51 a.m., clinical nurse supervisor (CNS)-A stated typically medications are sent back to the pharmacy upon discharge and a note will be written in the resident's progress notes. CNS-A stated when disposing of controlled medications, they will complete a count of the medications being disposed as well as the names of the medications, strength, and who medications are given to upon transfer. CNS-A stated this was typically only documented for narcotics. The licensee's 7.23 Medication Disposal policy indicated upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310			

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02310	Continued From page 46 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, and medical, or nursing standards for three of three residents (R2, R3, R5) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 11:06 a.m., during a tour of the facility, the surveyor observed hospital beds in the rooms of R2, R3, and R5. R2's hospital bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. Both bed rails at the head of the bed were in the raised position. The bed rails at the foot of the bed were in the low position. R3's bed had four bed rails installed bilaterally at the head of the bed and at the foot of the bed. The upper right bed rail was in the raised position and was pressed up against the wall of the bedroom. The other three bed rails on R3's bed were in the low position. R5's bed had two bed rails installed bilaterally at the head of the bed. The upper left bed rail was in the raised position and pressed up against the wall of the bedroom. The other	02310			

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02310	Continued From page 47 bed rails on R5's bed was in the low position. R2 R2 was admitted to the licensee on April 13, 2013, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R2's diagnosis included quadriplegia. R2's service plan dated October 29, 2015, indicated R2 received assisted living services to include medication setup and administration, transfer board assistance, positioning, therapeutic exercise, socialization, catheter care, bathing assistance, grooming, shopping assistance, and laundry. R3 R3 was admitted to the licensee on August 26, 2016, and began receiving assisted living services on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R3's diagnosis included antisocial personality disorder. R3's record lacked documentation of a service plan. On September 16, 2025, at 8:11 a.m., the surveyor observed clinical nurse supervisor (CNS)-A prepare and administer medications to R3. R5 R5 was admitted to the licensee on April 14,	02310			

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02310	Continued From page 48 2013, and began receiving assisted living service on August 1, 2021, with the implementation of Assisted Living licensing statutes under 144G. R5's diagnosis included Cardiovascular accident (CVA) and left sided hemiplegia. R5's service plan dated March 21, 2021, indicated R5 received assisted living services to include assistance with dressing, assistance with meals, oral hygiene, hair care, grooming, toileting assistance, assistance with bathing, stand by assistance, medication reminders, medication administration, hands on assistance with mobility transfers, housekeeping, laundry, behavior management, assistance with appointments, and socialization. R2, R3, and R5's records lacked documentation of: - purpose and intention of the bed rail; - measurements of the bed rail; - the resident's bed rail use/need assessment; - the resident's preferences; - physical inspection of bed rail(s) and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; - documentation to show the bed rails were FDA compliant, and; - documentation of the risk vs. benefits being discussed and documented with the resident/responsible party. On September 16, 2025, at 2:06 p.m., CNS-A stated they had completed training with staff on bed rail safety. CNS-A then asked if training	02310			

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02310	Continued From page 49 completed with staff was enough. CNS-A stated no physical assessments had been completed for bed rails and they were not aware of the requirement. The Licensee's undated 6.28 Side Rails policy, indicated that when the licensee is aware of a resident utilizing siderails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls.	02310			

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02310	Continued From page 50 This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

The James Inc
4533 Normandale Highlands Dr
Bloomington, MN 55437
Hennepin County
Parcel:

Phone:

License Info

License: HFID 30485

Risk:
License:
Expires on:
CFPM: James Imasuen
CFPM #: 3599; Exp: 08/02/2028

Inspection Info

Report Number: F1051251108
Inspection Type: Full - Single
Date: 9/15/2025 Time: 12:00:00 PM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

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

COMMENT:

AT THE TIME OF INSPECTION, JAMES IMASUEN'S CURRENT CFPM WAS NOT POSTED.

Comply By: 9/22/2025 Originally Issued On: 9/15/2025

New Order: 6-300 Physical Facility Numbers and Capacities

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

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

COMMENT:

AT THE TIME OF INSPECTION, THERE IS NO HANDWASHING SIGN POSTED IN THE RESTROOM IN THE BASEMENT.

Comply By: 9/17/2025 Originally Issued On: 9/15/2025

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, ZACHARY MORTH

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, FREDERICK:

EMPLOYEE ILLNESS LOG

VOMIT CLEAN-UP PROCEDURES

HANDWASHING & GLOVE USE/DISPOSAL

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 St Cloud District Office inspection report number F1051251108 from 9/15/2025

Frederick
Person in Charge

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

The James Inc
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1051251108
Inspection Type: Full
Date: 9/15/2025
Time: 12:00:00 PM

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No