Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2025

Licensee
Harmony House Of Brainerd I
218 9th Street Southwest
Brainerd, MN 56401

RE: Project Number(s) SL20415016

Dear Licensee:

On June 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 5, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

April 3, 2025

Licensee
Harmony House of Brainerd I
218 9th Street Southwest
Brainerd, MN 56401

RE: Project Number(s) SL20415016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(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 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: SL20415016-0 On March 3, 2025, through March 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was identified on March 4, 2025, at a level 3/Widespread (I). The licensee took action to mitigate risk on March 4, 2025; however, the scope and level remain at I.	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.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals with no assisted living contracts residing at the location. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license effective February 1, 2025. During the entrance conference on March 3, 2025, at 10:10 a.m., licensed assisted living director (LALD)-B stated the licensee had a current census of 20 residents. On March 3, 2025, at approximately 1:00 p.m., the environmental engineer stated during their tour of the facility, they had observed one occupied room in the basement with clothing and personal items and was informed by LALD-B this	0 130		

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0 130	Continued From page 5 room was occupied by an agency staff. The licensee's untitled document signed by unlicensed personnel (ULP)-D on April 4, 2024, noted the basement apartment "is not considered a resident room and will only be occupied by temporary staff on a temporary basis. I will not receive services therefore not requiring a signed assisted living contract. This apartment is available for use by temporary staff that need to be housed during the length of a contract with the staffing agency." The licensee's Staff Census Report dated March 3, 2025, identified ULP-D was an "As Needed" employee. On March 3, 2025, at 2:00 p.m., LALD-B stated ULP-D, an agency staff, had been living in the basement since April 2024. Minnesota Assisted Living Statutes 144G.08 definitions dated 2024, indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided.	0 130		

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0 130	Continued From page 6 TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
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: Based on interview and record review, the licensee failed to post a daily work schedule at	0 470		

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0 470	Continued From page 7 the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 22 residents, with a current census of 20 residents. During the entrance conference on March 3, 2025, at 10:10 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were familiar with the current minimum assisted living requirements. In addition, they stated they had staffing including 8 or 12 hour shifts, which included the day and afternoon shifts: three unlicensed personnel (ULP), and the night shift: two ULP. The licensee's posted Staffing for [licensee name], undated, noted: - day shift daily three ULP from 6:00 a.m. to 2:00 p.m.; - evening shift daily three ULP from 2:00 p.m. to 10:00 p.m.; and - overnight shift two ULP from 10:00 p.m. to 6:00 a.m. On March 3, 2025, at 12:10 p.m., LALD-B stated	0 470		

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0 470	Continued From page 8 the schedule was not posted every day. In addition, LALD-B stated they had different shifts, but there were always three ULP on between 6:00 a.m. to 2:00 p.m., three ULP from 2:00 p.m. to 10:00 p.m., and two ULP between 10:00 p.m. to 6:00 a.m. The licensee's Staffing & Scheduling policy dated August 1, 2021, noted the CNS would develop a 24-hour daily staffing schedule that would identify "direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and the direct-care staff member's resident assignments or work location." No further information was provided. TIME PERIOD OF 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	0 480		

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0 480	Continued From page 9 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480		

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0 480	Continued From page 10 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 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		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu	0 485		

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	20415	A. BUILDING: _____ B. WING _____	03/05/2025

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HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

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0 485	Continued From page 11 planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Assisted Living Contract dated January 2023, and signed on July 23, 2024, noted on page 3 under Access to Food: Meal Plans "Meals are included in the monthly rent." R1's Attachment C: Meal Plan Addendum dated revised January 2023, signed July 25, 2024, noted under Meal Plan Options: - "Resident can choose to participate in the Community's monthly meal plan, which provides 3 meals per day **Cost of monthly meal plan: Included in daily rate"; and - "Resident's can choose to opt out of the	0 485		

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0 485	Continued From page 12 Community's monthly meal plan. In that case, no meals would be provided. **Cost to opt out: Monthly rate reduction of $100." On March 5, 2025, at 11:25 a.m., regional manager (RM)-G stated it was all three meals or none, and further stated the meals were included in the cost of the rent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included restrictive airway disease status post lobectomy of the lung (surgical procedure to remove a lobe of the lung). On March 4, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Service Plan dated December 1, 2024, noted R1 received services including assistance with bathing, oxygen management, and medication administration. R1's Individual Abuse Prevention Plan dated January 28, 2025, noted R1 was at risk to be abused, and included specific measures to be taken to minimize the risk of abuse. However, it failed to address R1's risk of abusing other vulnerable adults. On March 5, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-A stated this was missed in R1's assessment. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted the plan would include the person's risk of abusing other vulnerable adults.	0 630		

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0 630	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the	0 680		

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0 680	Continued From page 15 required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on March 3, 2025, at 10:40 a.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entrance with a large common area with tables, chairs, and two offices. The surveyor observed a hallway to the left leading to the north unit and a hallway to the right leading to the south unit. Each unit consisted of bathrooms, resident rooms, a kitchen, and dining room. The licensee's yellow binder titled Emergency Preparedness Appendix Z dated as reviewed June 8, 2024, did not include: - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise;	0 680		

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0 680	Continued From page 16 - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On March 5, 2025, at 12:00 p.m., regional manager LALD-B stated the tests they had conducted included announced internal tornado drills. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated June 8, 2024, noted the site must conduct two testing exercises at least annually including "One exercise can be a table-top exercise and one must be a full-scale community-based participation exercise. If an exercise is not able to be completed, another table-top may be completed." Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	0 680		

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0 680	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure for five of five residents (R5, R6, R7, R8, R9) receiving hospice services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5 admitted to the facility on July 15, 2020. R6 admitted to the facility on July 27, 2023.	0 700		

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0 700	Continued From page 18 R7 admitted to the facility on October 25, 2023. R8 admitted to the facility on April 26, 2024. R9 admitted to the facility on January 25, 2024. On March 4, 2025, at 7:30 a.m., the surveyor observed a Home Care & Hospice After Hours form including R5, R6, R7, R8, and R9's first name and last initial, hospice provider name, and hospice telephone numbers in the dining area on the south unit taped to a cabinet to the right of the medication cart. The same posting was located in the same spot on the north unit. On March 5, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated the posting was on both units, and said it should not be posted where it is visible to residents and visitors of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to	0 775		

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0 775	Continued From page 19 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - Electromagnetic locks with keypads were installed on emergency exit doors. These exit doors required entry of a code into the keypad to unlock. A signal or switch was not installed that had the capability of unlocking the controlled egress locking system. During the facility tour interview M-C verified the above listed observations. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the locks. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. - On March 3, 2025, licensed assisted living director (LALD)-B provided emergency plan	0 775		

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0 775	Continued From page 20 procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system. During an interview on March 3, 2025, at 1:50 p.m., LALD-B verified this information was not included in the plan. Fire Door Maintenance In the north basement, a labeled one hour fire door with an electromagnetic door holder was propped open by the placement of storage bins in front of the door. During the tour interview, M-C verified the above listed fire door observation. Electromagnetic door holders must be maintained as designed to hold open self-closing fire doors until released by the fire protection system. Ceiling Maintenance In the basement laundry/storage area, several ceiling tiles were missing. During the tour interview, M-C verified the above listed observation. Missing ceiling tiles would allow smoke and heat to rise into the space above the ceiling and could delay fire sprinkler activation. Smoking Material Disposal Three burnt cigarettes had been disposed of on the ground in the designated outdoor smoking area. During the facility tour interview M-C verified smoking materials had been improperly disposed. Improper disposal of smoking materials creates a fire hazard. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 21	0 780		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect more than a limited number of 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	0 780		

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0 780	Continued From page 22 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed two rooms in the basement were furnished as sleeping rooms, with beds. One room was occupied with a person in bed and the other room was vacant. Smoke alarms were not installed in these sleeping rooms. During the facility tour interview, M-C stated these bedrooms were used as temporary staff sleeping quarters and verified smoke alarms were not installed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 23 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect some 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 3, 2025, licensed assisted living	0 810		

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0 810	Continued From page 24 director (LALD)-B and maintenance (M)-C provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP floor plan failed to accurately identify the location and number of resident sleeping rooms. - On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed numbers were posted at the resident sleeping room doors. The resident sleeping rooms were numbered 1-10 in the north building and 1-10 in the south building. - Record review of the available documentation indicated the FSEP floor plan labeled the resident sleeping rooms in the south building as 11-20. These sleeping room labels did not match the numbers posted at the doors. During the facility tour interview, M-C verified the resident sleeping room numbers on the floor plan did not match the numbers posted at the doors in the south building. Accurate resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. The numbers posted at the resident sleeping room doors must correspond with the number labels on the FSEP floor plan. - Additionally, there were two FSEP floor plans posted in the south building that did not label any of the resident sleeping rooms by number. During the facility tour interview, M-C verified these floor plans were lacking sleeping room number labels. Record review indicated the licensee FSEP was	0 810		

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0 810	Continued From page 25 not developed and maintained for the facility. - On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed the doors leading into the south and north buildings from the shared common area of the building had been removed. Record review of the available documentation indicated the FSEP floor plan inaccurately included door symbols in these locations. During the facility tour interview, M-C verified doors had previously been installed in these locations but had been removed. - On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed ANSUL systems were not installed in either of the kitchens. Record review indicated the FSEP inaccurately referenced an ANSUL (anhydrous sulfur dioxide) hood suppression system. Additionally, the FSEP referenced smoke compartments, pull fire stations, and fire doors, but these locations were not identified in the plan. The FSEP must be developed and maintained relative to the facility's building layout, environmental risks, and the building occupants. During an interview on March 3, 2025, at 1:50 p.m., LALD-B verified the FSEP required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	0 970		

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0 970	Continued From page 26 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract dated January 2023, included the following clauses on page 11: - "22. Indemnification. As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guest and agents. Resident will indemnify and hold harmless Provider, its employee's officers, manager, owner, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents"; and	0 970		

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0 970	Continued From page 27 - "24. Liability. Provider is not liable to Resident or Resident's guests for any injury, death, or property damage occurring in the Apartment or on Provider's premises unless such injury, death, or property damage occurs as the result of Provider's own negligent acts or omissions or those of its employees, officers, managers, owners, or agents. Provider is also not liable for any injury, death, or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third party providers. Unless caused by one of the aforementioned accepted reasons, Resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises." On March 5, 2025, at 11:25 a.m., regional manager (RM)-G stated these items were removed from the new contract, but had not been implemented for all residents, and was unable to state how many residents had the contract with the above verbiage in it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290		

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01290	Continued From page 28 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study completed via NetStudy 2.0 for 2 of 35 employees (unlicensed personnel/ULP-E, ULP-F). In addition, the licensee failed to ensure background studies were affiliated with the assisted living facility's health facility identification (HFID) for 1 of 35 employees (maintenance (M)-C). This had the potential to affect all residents, employees, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on	01290		

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01290	Continued From page 29 March 4, 2025. During the entrance conference on March 3, 2025, at 10:10 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required contents of an employee record. ULP-E ULP-E was hired on June 16, 1998, to provide direct care services to residents of the facility. On March 4, 2025, at 7:20 a.m., the surveyor observed ULP-E in the dining room on the north unit, providing breakfast and interacting with residents. The licensee's weekly schedules indicated ULP-E worked six days, varying shifts, for the licensee from March 2, 2025, through March 15, 2025. ULP-E's employee record lacked a current cleared background study. ULP-F ULP-F was hired on September 26, 2016, to provide direct care services to residents of the facility. On March 4, 2025, from 7:50 a.m. to 8:30 a.m., the surveyor observed ULP-F on the south unit, providing breakfast and medications to residents. The licensee's weekly schedules indicated ULP-F worked eight days, varying shifts, for the licensee from March 2, 2025, through March 15, 2025. ULP-F's employee record lacked a current cleared background study. M-C	01290		

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01290	Continued From page 30 M-C was hired on September 9, 2021, to provide maintenance for the facility. M-C's employee record included a cleared background study. However, it was not affiliated with the licensee's HFID. The licensee's NETStudy 2.0 roster, dated March 3, 2025, noted: - ULP-E "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022; and - ULP-F "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022. On March 4, 2025, at 10:10 a.m., regional manager (RM)-G stated she was aware the background studies for ULP-E and ULP-F were expired after the roster was pulled, and she checked to be sure no current background study was available. In addition, RM-G stated M-C's background study was not affiliated with the HFID. The licensee's Background Checks policy dated August 1, 2021, noted the licensee would conduct a background study on all team members and volunteers, and "No team member may have independent direct contact with any tenants or clients until acceptable result of the background study have been received." Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program.	01290		

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01290	Continued From page 31 Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 4, 2025, the licensee took action to mitigate the risk; however, the scope and level remains at I.	01290		
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	01760		

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01760	Continued From page 32 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of 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's diagnoses included vascular dementia (a type of dementia caused by damage to the blood vessels in the brain) and hypertension (high blood pressure). On March 4, 2025, at 8:27 a.m., the surveyor observed unlicensed personnel (ULP)-F check R2's blood pressure, with a result of 104/69, and administer R2's medications, including losartan 25 milligrams (mg). R2's Service Plan dated March 3, 2025, noted R2 received services including daily blood pressure and medication administration.	01760		

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01760	Continued From page 33 R2's prescriber orders dated January 27, 2025, included: - losartan (causes blood vessels to tighten) for hypertension, with instructions "Give 25 mg by mouth one time a day. HOLD med [medication] if blood pressure is 140/80 or less." On March 4, 2025, at 2:36 p.m., clinical nurse supervisor (CNS)-A stated the losartan should not have been given with the blood pressure lower than 140/80 per the prescriber's order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident with inhalers (R1) and failed to date time sensitive medications with a date when opened for two of two residents' time sensitive medications (R1, R2). This practice resulted in a level two violation (a	01890		

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01890	Continued From page 34 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 3, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. On March 4, 2025, at 8:00 a.m., the surveyor observed the medication cart on the south unit with unlicensed personnel (ULP)-I, whom confirmed the findings. R1's Ellipta inhaler (used to deliver medications for respiratory conditions such as asthma and chronic obstructive pulmonary disease/COPD) was in the section of the medication cart with R1's other medications. However, it lacked a prescription label and lacked a date when opened. R2's Novolog FlexPen (injectable insulin) lacked a date when opened. On March 5, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated the expected medications to have the original prescription label and expected both the Ellipta inhaler and the Novolog FlexPen were dated when opened. The manufacturer's directions for Ellipta inhaler dated January 7, 2019, noted the inhaler should	01890		

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01890	Continued From page 35 be discarded six weeks from the date the tray was opened. The manufacturer's directions for Novolog FlexPen dated February 2025, noted the pen should be thrown away after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=D	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to mitigate a safety risk identified in the facility hazard vulnerability assessment of the physical environment. 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	02040		

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02040	Continued From page 36 resident's health or safety) 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). Findings include: On March 3, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance (M)-C. During the facility tour, the surveyor observed cleaning supplies and chemicals were stored in an unlocked cabinet under the sink in the gathering room. The gathering room was not being supervised by staff. During the facility tour interview, M-C verified the chemical storage observation. On March 3, 2025, licensed assisted living director LALD-(B) provided a memory care hazard vulnerability assessment tool. Cleaning supplies and chemicals were identified as hazards and mitigation of these hazards was not part of the assessment. During an interview on March 3, 2025, at 1:50 p.m., LALD-B verified this hazard was not mitigated to protect dementia care residents from harm. TIME PERIOD FOR CORRECTION: Two (2) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:	02170		

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02170	Continued From page 37 (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for two of two residents (R1, R2) who resided in an assisted	02170		

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02170	Continued From page 38 living with dementia care 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: The licensee had an Assisted Living with Dementia Care license effective February 1, 2025. R1 R1's diagnoses included restrictive airway disease status post lobectomy of the lung (surgical procedure to remove a lobe of the lung). On March 4, 2025, at 10:50 a.m., the surveyor observed R1 attending a music activity, and dancing. R1's Service Plan dated December 1, 2024, noted R1 received services including assistance with bathing, oxygen management, and medication administration. R1's undated, Resident History / Bio noted past and current interests. However, it lacked: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; and - adaptations necessary for the resident to participate.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(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
02170	Continued From page 39 In addition, R1's record lacked an individualized activity plan based on the activity evaluation. On March 4, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-A stated the history and bio lacked the required information. CNS-A also stated there was a format in their electronic record system with the information but it has not been utilized yet. R2 R2's diagnoses included vascular dementia (a type of dementia caused by damage to the blood vessels in the brain) and hypertension (high blood pressure). R2's Service Plan dated March 3, 2025, noted R2 received services including daily blood pressure and medication administration. R2's record lacked an activity evaluation and individualized activity plan. On March 4, 2025, at 2:36 p.m., regional manager (RM)-G stated she believed the history and bio was in a box from the previous director and was unable to locate it. The licensee's Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility, and the evaluation must address past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, and identification of activities for behavioral interventions. It also noted a individualized activity plan must be developed for each resident based	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(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
02170	Continued From page 40 on the activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of one resident (R1).	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(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
02180	Continued From page 41 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: The licensee had an Assisted Living with Dementia Care license effective February 1, 2025. R1's diagnoses included restrictive airway disease status post lobectomy of the lung (surgical procedure to remove a lobe of the lung). R1's Service Plan dated December 1, 2024, noted R1 received services including assistance with bathing, oxygen management, and medication administration. R1's Resident Notes dated December 17, 2024, through February 19, 2025, included multiple entries where R1 had behaviors including yelling at staff or other residents using expletive language, and pushing R1's walker into them. On March 4, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-A stated R1's record lacked any specific monitoring for behaviors and any specific interventions for staff to utilize with behaviors. In addition, CNS-A stated with this pattern of behaviors, there should be monitoring. The licensee's Behavioral Symptoms, Interventions & Nonpharmacological Approaches	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(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
02180	Continued From page 42 policy dated August 1, 2021, noted the licensee would "identify behavioral symptoms that negatively impact other residents and others in the assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions will be identified on the care plan or service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02310 SS=D	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 one of three residents (R5) with oxygen storage. 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).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 43 The findings include: On March 3, 2025, at 1:24 p.m., the surveyor observed R5's closet in her apartment, with two unsecured oxygen tanks upright on the floor. At this time, maintenance (M)-C placed the tanks in a holder, and stated sometimes outside providers bring in the oxygen and place them without a holder. R5's Service Plan dated December 1, 2024, indicated R5 received services including assistance with bathing, medication administration, and oxygen. R5's prescriber orders dated February 18, 2025, included oxygen via nasal cannula two liters per minute. On March 3, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated the oxygen tanks should be stored in a holder. The licensee's Oxygen policy dated August 1, 2021, noted oxygen cylinders and vessels must remain upright at all times. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *03/03/25*
Time: 11:30:56
Report: 1037251066

Food and Beverage Establishment Inspection Report

Location:
Harmony House Of Brainerd I
218 9th Street Sw
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0038687
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 8777284142
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELLED EGGS WERE BEING STORED ABOVE READY TO EAT FOODS. STORE RAW ANIMAL FOODS BELOW READY TO EAT FOODS.

Comply By: 03/03/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS RECENTLY DISMISSED FROM THE ESTABLISHMENT. EMPLOY A CFPM WITHIN 60 DAYS.

Comply By: 05/03/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER - NORTH
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER - SOUTH
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/03/25*
Time: 11:30:56
Report: 1037251066
Harmony House Of Brainerd I

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler - BASEMENT
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED CHEESE
Violation Issued: No

Process/Item: Upright Cooler - SOUTH
Temperature: 39 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Upright Cooler - NORTH
Temperature: 38 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
1	0	1	

DISCUSSED MENU, BARE HAND CONTACT, COOLING, REHEATING, EMPLOYEE ILLNESS RECORDING, AND ORDERS.
FOOD ITEMS ARE PREPPED FOR IMMEDIATE SERVICE, NO ONSITE COOLING.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037251066 of 03/03/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
BRANDY

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037251066

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/03/25
Time In 11:30:56
Time Out

Harmony House Of Brainerd I	Address: 218 9th Street Sw	City/State: Brainerd, MN	Zip Code: 56401	Telephone: 8777284142
License/Permit #: 0038687	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	(OUT)	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/03/25

Inspector (Signature) Michelle L Hoveras