



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 29, 2025

Licensee

Bay Harbor Senior Living of La Crescent
1384 County Road 25
La Crescent, MN 55947

RE: Project Number(s) SL33651016

Dear Licensee:

On December 11, 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 26, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 26, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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.

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>

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/11/2025
NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947		
(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 SL33651016-1 On December 8, 9, 2025, and December 11, 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 26, 2025. At the time of the survey, there were 76 residents; 65 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued: 1420, 1640, 1650.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

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{01420}	Continued From page 3 procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-F, ULP-J, ULP-P) completed all training and competency evaluations prior to providing delegated nursing tasks to one of one resident (R4) with a Pure wick urinary system. 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: R4 R4 began receiving services from the licensee on July 7, 2018, with diagnoses including cerebrovascular disease (disease process affecting the brain/blood vessels), history of stroke with left sided weakness/hemiparesis, type		{01420}		

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{01420}	Continued From page 4 2 diabetes, and depression. R4's Service Agreement dated February 3, 2025, included the service of Pure wick urinary system (an external apparatus placed on R4 to capture urine) with note: Apply Pure wick system at bedtime. Clean perineum. Do not use any Vaseline with this device. Use one wick per night. Further note included: Remove Pure wick system at in the morning upon rising. Clean perineum. Vaseline for barrier during day hours. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J stated she worked with all residents in the secured unit. ULP-J stated R4's Pure wick system had been removed earlier in the morning. ULP-F ULP-F had a hire date of February 18, 2020, to provide direct care services to the licensee's residents. On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F stated she worked with all residents in the assisted living area and with all residents in the secured unit. ULP-J ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents.	{01420}			

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{01420}	Continued From page 5 ULP-P ULP-P had a hire date of October 6, 2025, to provide direct care services to the licensee's residents. ULP-F, ULP-J, and ULP-P's employee's records lacked evidence of training and/or demonstrated competency for R4's Pure wick urinary system. On December 8, 2025, at 12:46 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not gotten all ULP trained on the purewick system; and further stated, "Some are done and some are not, and we are working on those now." The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated A registered nurse or licensed health professional at [licensee name] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The facility will establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. The policy further indicated when the registered nurse or licensed health professional at [licensee name] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to	{01420}			

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{01420}	Continued From page 6 competently follow the procedures and perform the tasks. No further information provided.	{01420}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all 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 ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for two of four residents (R11, R14).	{01640}			

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{01640}	Continued From page 7 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: R11 R11 began receiving services under the licensee's Assisted Living with Dementia Care license on November 26, 2024, with diagnoses including dementia with psychotic disturbance, and type 2 diabetes. During the survey conducted in September 2025, the licensee provided the surveyor with R11's unsigned, Service Agreement indicating an effective date of September 26, 2025 (during survey), and included the services of assistance with dressing, bathing, toileting, blood sugar checks, and compression stockings. R14 R14 began receiving services under the licensee's assisted living with dementia care license on March 29, 2022, with diagnoses including Alzheimer's disease and depression. During the survey conducted in September 2025, the licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing, and ambulation. R14's Service Agreement lacked the	{01640}			

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{01640}	Continued From page 8 service of medication administration. On December 8, 2025, at 8:45 a.m., the surveyor requested R11 and R14's current signed Service Agreements. Neither were provided. On December 8, 2025, at 12:50 p.m., LALD/CNS-A stated R11 and R14's Service Agreements had not yet been signed by the resident/resident representative, nor the facility representative as required, and did not know why they were not completed since the previous survey. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by [licensee's name] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01640}			
{01650} SS=D	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:	{01650}			

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{01650}	Continued From page 9 (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 one of two residents (R14) who received 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 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: R14 began receiving services under the licensee's Assisted Living with Dementia Care license on March 29, 2022, with diagnoses including Alzheimer's disease and depression.	{01650}			

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{01650}	Continued From page 10 The licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing, and ambulation. R14's Service Agreement lacked the service of medication administration. R14's medication administration record (MAR) dated September 2025, indicated she received scheduled medications including one for constipation, one supplement, one for blood pressure, and one for depression. R14's MAR also indicated as needed (PRN) medications including one for mild pain, one for significant pain, two for constipation, one for heartburn, one for cough, one for dermatitis, one for agitation, one for skin itching/rash, one for anxiety, one for excessive secretions, one for chest pain and one for nausea/vomiting. On December 8, 2025, the surveyor requested R14's current signed Service Agreement, which was not provided. On December 8, 2025, at 12:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R14's service agreement had not been updated nor signed since the previous survey completed in September 2025, and was not sure how it was missed. On December 8, 2025, at 3:30 p.m., unlicensed personnel (ULP)-Q stated R14 no longer had diclofenac gel in the medication cart but did receive medication administration from the licensee's staff. The licensee failed to ensure medication administration was part of R14's Service	{01650}			

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{01650}	Continued From page 11 Agreement. The licensee's Service Plan policy dated August 1, 2021, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan includes the following: - a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; - the fees for services and the frequency of each service according to the resident's current review or assessment and resident preferences; and - the identification of the staff or categories of staff who will provide the services No further information was provided.	{01650}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 28, 2025

Licensee

Bay Harbor Senior Living of La Crescent
1384 County Road 25
La Crescent, MN 55947

RE: Project Number(s) SL33651016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 26, 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:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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).

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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.

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<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/Bm5uQEpHVv>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947			
(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: SL33651016-0 On September 22, 2025, through September 26, 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 70 residents; 59 receiving services under the Assisted Living Facility with Dementia Care license. 1310-An immediate order was issued on September 23, 2025, at a level 2/Widespread (F) The licensee took action on September 23, 2025; however, the scope and level remain at F.	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.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the survey from September 22, 2025, through September 26, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents. The licensee had an assisted living with dementia care (ALFDC) license effective December 1, 2024.	0 420			

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0 420	Continued From page 2 The licensee's "Application for Assisted Living License, section titled "Official Verification of Owner or Authorized Agent", (page four of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page five was electronically signed by the owner/agent on September 16, 2024. As a result of this survey, the following orders were issued under 0480, 0510, 0650, 0660, 0680, 0775, 1060, 1310, 1320, 1330, 1420, 1440, 1470, 1500, 1540, 1620, 1640, 1650, 1760, 1820, 1890, 1950, 2110, 2170, 2180, 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.	0 420			

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0 420	Continued From page 3	0 420			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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	0 480			

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0 480	Continued From page 4 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 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:	0 480			

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 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			
0 510 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: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of six unlicensed personnel (ULP-J) during personal cares. This had the potential to affect all residents and staff within the facility. This practice resulted in a level two violation (a	0 510			

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0 510	Continued From page 6 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 23, 2025, at 10:00 a.m., the surveyor observed ULP-J and ULP-H both don gloves and assist R4 to transfer from her Broda chair (specialized wheelchair) to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change by removing the soiled brief, cleansing the skin of stool and urine, placed a clean brief on R4 and pulled up R4's pants. ULP-J continued with the same gloves to reattach the Hoyer sling straps to the Hoyer lift and assisted with transferring R4 back to her Broda chair. ULP-J continued with the same gloves and adjusted the Broda chair to a reclining position to allow for better placement in the chair for R4. ULP-J then placed a blanket on R4's lap and then removed her gloves and sanitized her hands. ULP-J failed to remove soiled gloves and sanitize her hands immediately following providing a soiled incontinence brief change and before touching other surfaces (sling, lift, Broda chair, clothing/blanket). On September 23, 2025, at 10:10 a.m., ULP-J stated she "didn't think about the in-between steps in touching other surfaces" after changing a soiled brief and the need to remove her gloves	0 510			

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0 510	Continued From page 7 and sanitize her hands. On September 24, 2025, at 1:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staff are expected to remove soiled gloves and sanitize hands prior to touching and potentially contaminating other surfaces. The licensee's Handwashing policy dated August 1, 2021, indicated proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed after changing diapers or cleaning up after someone who has used the toilet. The policy also indicated: when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and	0 650			

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0 650	Continued From page 8 competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-F, ULP-J). 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-F ULP-F had a hire date of February 18, 2020, to provide direct care services to the licensee's residents.	0 650			

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0 650	Continued From page 9 On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F's record lacked evidence of documentation of training for setting up medications for residents' unplanned time away. ULP-J ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. ULP-J's record lacked evidence of documentation of training for setting up medications for residents' unplanned time away. On September 24, 2025, at 1:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had a procedure for setting up medications for a resident's unplanned time away. The ULP were to set up medications for unplanned time away and it was available in the policy book for ULP reference. LALD/CNS-A further stated the training was "covered by the ULP helping with training on the floor"; however, this training was not documented anywhere. The licensee's Employee Records policy dated August 1, 2021, indicated employee records for each person will include records of all training and in-service education required and/or provided including record of competency testing as required.	0 650			

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0 650	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of two employees (unlicensed personnel (ULP)-F, ULP-J). This had the potential to affect all residents within the facility.	0 660			

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0 660	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated August 18, 2025, indicated the licensee was a low risk. ULP-F ULP-F had a hire date of February 18, 2020, to provide direct cares to the licensee's residents. On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F's employee record included a TB symptom screening dated January 30, 2020. ULP-F indicated "no" to the question "Have you had a TB test in the past 12 months?" ULP-F's employee record included a one-step TST dated February 27, 2020; however, lacked a second step TST as required. On September 24, 2025, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she understood per Minnesota Department of Health (MDH) guidelines indicated a one-step TST was	0 660			

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0 660	Continued From page 12 acceptable as long as subsequent TST were completed annually. LALD/CNS-A stated ULP-F should have had a second step done each year since her hire date and hadn't. On September 24, 2025, at 2:15 p.m., LALD/CNS-A provided the surveyor with a screenshot of her computer screen which included the following: "Not required yearly. In Minnesota, a two-step TB test is not required yearly for most health care personnel. Instead, a baseline screening is conducted, and subsequent testing is based on occupational risk factors. Personnel who have not had a Mantoux test within the last year are required to undergo two-step testing, but those with a documented history of a negative skin test within the past year only need a single test." ULP-F's symptom screening indicated she had not had a TB test in the previous 12 months, thus lacked a history of a negative test within the past year. The licensee failed to ensure ULP-F completed a second step TST. ULP-J ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's employee record included the first step	0 660			

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0 660	Continued From page 13 TST completed on February 24, 2025; however, the record lacked a TB symptom screening and second step TST. On September 26, 2025, at 10:05 a.m. LALD/CNS-A stated since she understood a one-step TST annually was required, ULP-J would not need another skin test until next February. Regarding ULP-J's symptom screening, LALD/CNS-A stated, "this is odd as it should have been kept within ULP-J's employee file." The licensee's Tuberculosis Screening dated August 1, 2021, indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers) . 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file.	0 660			

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0 660	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff 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 review and update an all-hazards risk assessment emergency	0 680			

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0 680	Continued From page 15 preparedness program and plan to include Appendix Z required elements and failed to post the plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 26, 2025, at 12:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "I don't handle that, the housing manager does, and he is giving a tour, right now", when asked who the surveyor could talk to review the facility EP (emergency preparedness) plan. On September 26, 2025, at 2:06 p.m., the surveyor requested the facility's emergency preparedness (EP) plan from receptionist (R)-O. R-O obtained the EP binder from an office area as stored in an emergency bin. R-O indicated the EP binder is stored in this location; however, the office door is closed and locked after business hours. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - the licensee's plan lacked evidence it was reviewed/updated since June 14, 2022,	0 680			

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0 680	Continued From page 16 - the licensee failed include evidence they reviewed the missing resident procedure quarterly as required, - the licensee failed to indicate evidence they conducted the required minimum two facility exercises annually. The surveyor noted two blank tabletop exercises in the EP binder dated January 16, 2013, and July 17, 2025. Neither document had information entered. On September 26, 2025, at 2:30 p.m., the surveyor attempted contact with HM-M to further discuss the missing elements of the facility's EP plan. R-O indicated housing manager (HM)-M, LALD/CNS-A, and administrators were out of the building and would not be returning for the day. The licensee's Emergency Preparedness Plan-Appendix Z Compliance dated August 1, 2021, indicated [licensee's name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components. Exercises and Drills - [licensee name] will conduct, at minimum, two emergency preparedness drills every 12 months - these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement.	0 680			

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0 680	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. 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 the potential to affect a large portion or all of the residents). The findings include: On September 24, 2025, from approximately 11:30 a.m. to 1:40 p.m., the surveyor toured the facility with house manager (HM)-M and maintenance supervisor (MS)-L. During the tour the surveyor observed the following: A patio gate was secured with a padlock in the	0 775			

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0 775	Continued From page 18 egress pathway. A gate leading out from the patio of the memory care unit was secured shut via use of a padlock requiring a key to open. Exit doors and gates should be maintained free of locks requiring special knowledge, tools or effort. The unapproved lock should be removed, and the gate should be maintained with only approved locking mechanisms. A furnace closet near the front entry had holes present in the rated walls where wires were installed. Rated walls should be maintained free of openings. HM-M stated that the wires had recently been added and that the holes would be filled with properly rated materials. Extension cords were in use in resident room C229 to power multiple devices including a lamp and alarm clock. Extension cords are not rated for continuous use and should not be used in lieu of permanent wiring. Use of extension cords in this capacity increases risk of fire. MS-L acknowledged use of extension cords and stated that they would be removed from resident rooms. A sprinkler head was obstructed by bags and boxes in the closet area between the bedroom and bathroom in resident room B222. The dryer ventilation was not properly attached to the clothing dryer on the independent side of the facility. Dryer lint had accumulated behind the dryer which may pose a risk of fire. MS-L and HM-M acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			

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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.	01060			

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01060	Continued From page 20 (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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R11). 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: R11 was admitted to the licensee on November 26, 2024, with diagnoses including unspecified dementia with psychosis, and type 2 diabetes. R11's unsigned/undated, Service Agreement indicated she received services including assistance with medication management/administration, blood sugar checks, compression stockings, bathing, dressing and toileting. R11's progress notes included an entry on September 26, 2025, that read, "Late Entry for	01060			

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01060	Continued From page 21 9/19/2025 4:00 AM: Resident had a fall and was transported to [hospital name]. Her daughter was notified." R11's record lacked a written notice that contained, 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 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; - 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. In addition, R11's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On September 26, 2025, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the requirements regarding a resident's emergency relocation and the need to notify the Office of Ombudsman for Long-Term Care. The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, [licensee name] will provide a written notice that contains, at a	01060			

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01060	Continued From page 22 minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060			
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as staff members of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced	01310			

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01310	Continued From page 23 by: Based on observation, interview, and record review, the licensee failed to ensure a licensed practical nurse (LPN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of one employee (LPN-B). This had the potential to affect all residents and staff. This resulted in an immediate correction order issued on September 23, 2025. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 22, 2025, at 11:10 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was the primary nurse for the facility, was in the facility at least five days each week, and provided on-call coverage for the after-hours needs in the facility. LALD/CNS-A further stated the licensee employed one LPN who assisted with nursing duties as LALD/CNS-A delegated. LPN-B was hired on January 3, 2023, and provided direct nursing cares for the licensee's residents. R1's progress notes dated September 15, 2025, through September 17, 2025, included nursing	01310	The licensee submitted an acceptable plan of correction to address the immediate; the scope and severity remain at level 2, widespread.		

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01310	Continued From page 24 notes documented by LPN-B. LPN-B's employee record included a signed job description dated December 7, 2022. The job description indicated the following requirements: -a graduate from an accredited LPN program; - and -currently licensed to practice in the State of Minnesota as a licensed practical nurse. LPN-B's employee record included a credential/license summary, printed September 22, 2025, at 3:34 p.m. The summary indicated LPN-B held a Wisconsin LPN license with an expiration date of April 30, 2027. The document further indicated LPN-B held a "multi-state" license. On September 22, 2025, at 3:45 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which lacked evidence LPN-B held a Minnesota LPN license. On September 22, 2025, at 4:30 p.m., LPN-B stated she completed assigned duties as delegated by LALD/CNS-A, including obtaining resident vital signs, gathering information regarding resident illnesses, helping with updating resident services, "chatting" with residents about services received and resident needs. LPN-B stated all information obtained, and observations were reported to LALD/CNS-A. On September 22, 2025, at 4:35 p.m. LPN-B stated when she started her employment with the licensee, she understood her Wisconsin LPN license as a "multi-state" license, was recognized by the Minnesota Board of Nursing which then	01310			

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01310	Continued From page 25 allowed her to practice in the facility located across the Minnesota-Wisconsin border. LPN-B stated when she initially (believed to be in 2022) applied for the multi-state license she referenced a map and was certain Minnesota Board of Nursing was allowing this type of license. On September 23, 2025, at 10:30 a.m. LPN-B stated she was unable to find documentation to support her understanding of her ability to work across the Wisconsin border and practice as an LPN in Minnesota. LPN-B stated it may have been during the Covid-19 period with a previous employer and was led to believe she was "in compliance". The Minnesota Board of Nursing Border State License Recognition Fact Sheet dated July 28, 2025, indicated "other state's nursing licenses including a license labeled "multi-state", are not valid in Minnesota, except under identified legal circumstances." On September 23, 2025, at 10:45 a.m. the surveyor contacted a representative from the Minnesota Board of Nursing. The representative stated the Minnesota Board of Nursing did not recognize border state reciprocity for nursing licenses. She stated LPN-B needed to either apply for a Minnesota LPN license or apply for a "border state license". She further stated if LPN-B wished to pursue a border state license, she would complete the application which allowed her to work in one facility/clinic only. The licensee's Staffing Requirements-licensed nurse and unlicensed personnel (ULP) policy dated August 1, 2021, indicated Licensed health professionals and nurses providing services as	01310			

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NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947			
(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
01310	Continued From page 26 employees of a licensed facility must possess a current Minnesota license or registration to practice. Minnesota State Statute 148.283 UNAUTHORIZED PRACTICE OF PROFESSIONAL, ADVANCED PRACTICE REGISTERED, AND PRACTICAL NURSING indicated, "The practice of advanced practice, professional, or practical nursing by any person who has not been licensed to practice advanced practice, professional, or practical nursing under the provisions of sections 148.171 to 148.285, or whose license has been suspended or revoked, or whose registration or national credential has expired, is hereby declared to be inimical to the public health and welfare and to constitute a public nuisance. Upon a complaint being made by the board or any prosecuting officer, and upon a proper showing of the facts, the district court of the county where such practice occurred may enjoin such acts and practice. Such injunction proceeding shall be in addition to, and not in lieu of, all other penalties and remedies provided by law." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on September 23, 2025; however, the scope and level remain at F.	01310			
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the	01320			

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01320	Continued From page 27 services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed by one of two unlicensed personnel (ULP-J) prior to providing direct cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents.	01320			

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01320	Continued From page 28 On September 23, 2025, at 10:00 a.m. the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's employee file lacked evidence of training prior to providing services for the following: 1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) understanding appropriate boundaries	01320			

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01320	Continued From page 29 between staff and residents and the resident's family; (13) procedures to use in handling various emergency situations; and (14) awareness of commonly used health technology equipment and assistive devices. Additionally, ULP-J's employee file lacked evidence she completed a practical skills test or had the RN indicate her competency in the following tasks as required: -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them On September 24, 2025, at 12:00 p.m., business manager (BM)-K stated ULP-J had not completed any of the Educare training (the licensee's online training system) modules as assigned. BM-K further stated ULP-J had been assigned the trainings on about February 17, 2025, and had been talked to and given a deadline to complete the required training. On September 24, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "I was just made aware she (ULP-J) had not completed her Educare training and slipped through the cracks." The licensee's Orientation and Training Competency Training Evaluations policy dated August 1, 2021, indicated when a registered	01320			

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01320	Continued From page 30 nurse or licensed health professional staff of [licensee name] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. -Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. - The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies. - Training and competency evaluations of ULPs will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. - Training and competency evaluations for all ULPs will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing	01320			

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01320	Continued From page 31 ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
01330 SS=D	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	01330			

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01330	Continued From page 32 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 competency training and evaluations were completed by one of two unlicensed personnel (ULP-J) prior to providing direct cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to	01330			

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01330	Continued From page 33 her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's training record lacked the following required training and competency topic prior to providing services: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning On September 24, 2025, at 12:00 p.m. business manager (BM)-K stated ULP-J had not completed any of the Educare training (the licensee's online training system) modules as assigned. BM-K further stated ULP-J had been assigned the trainings on about February 17, 2025, and had been talked to and given a deadline to complete the required training. On September 24, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "I was just made aware she (ULP-J) had not completed her Educare training and slipped through the cracks." The licensee's Orientation and Training Competency Training Evaluations policy dated August 1, 2021, indicated when a registered	01330			

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01330	Continued From page 34 nurse or licensed health professional staff of [licensee name] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the	01420			

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01420	Continued From page 35 unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-F, ULP-J) completed all training and competency evaluations prior to providing delegated nursing tasks to one of one resident (R4) with a Pure wick urinary system. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R4 R4 began receiving services from the licensee on July 7, 2018, with diagnoses including cerebrovascular disease (disease process affecting the brain/blood vessels), history of stroke with left sided weakness/hemiparesis, type 2 diabetes, and depression.	01420			

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01420	Continued From page 36 R4's Service Agreement dated February 3, 2025, included the service of Pure wick urinary system (an external apparatus placed on R4 to capture urine) with note: Apply Pure wick system at bedtime. Clean perineum. Do not use any Vaseline with this device. Use one wick per night. Further note included: Remove Pure wick system at in the morning upon rising. Clean perineum. Vaseline for barrier during day hours. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J stated she worked with all residents in the secured unit. ULP-J stated R4's Pure wick system had been removed earlier in the morning. ULP-F ULP-F had a hire date of February 18, 2020, to provide direct care services to the licensee's residents. On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F stated she worked with all residents in the assisted living area and with all residents in the secured unit. ULP-J ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. ULP-F and ULP-J employee's records lacked	01420			

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01420	Continued From page 37 evidence of training and/or demonstrated competency for R4's Pure wick urinary system. On September 26, 2025, at 11:15 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she and licensed practical nurse (LPN)-B reviewed use of the Pure wick urinary system; however, they did not provide training or competency for the unlicensed personnel. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated A registered nurse or licensed health professional at [licensee name] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The facility will establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. The policy further indicated when the registered nurse or licensed health professional at [licensee name] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information provided.	01420			

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01420	Continued From page 38	01420			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of one of two unlicensed personnel (ULP-J) performing delegated tasks was provided by the registered nurse (RN) within 30	01440			

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01440	Continued From page 39 calendar days after the date on which the individual began working for the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's employee file lacked evidence the licensee's registered nurse (RN) completed a 30-day supervisory observation on performing delegated tasks. On September 26, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not certain, but "felt the 30-day review was completed." She further stated she would investigate it further. No further response/documentation of a RN supervisory observation was provided.	01440			

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NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947			
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01440	Continued From page 40 The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470			

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01470	Continued From page 41 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two	01470			

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01470	Continued From page 42 employees (unlicensed personnel (ULP)-J) received orientation to assisted living facility licensing requirements and regulations before providing 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's record lacked evidence she received orientation to assisted living facility to include the following required content: - an overview of Assisted Living Statutes; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470			

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01470	Continued From page 43 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On September 24, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-J received some training on her first day of hire with the administrative team; however, further training as indicated above, was assigned through Educare and ULP-J had not completed the assigned trainings. The licensee's Orientation or Staff and Supervisors and Content policy dated August 1, 2021, indicated all the licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: - An overview of the appropriate Assisted Living statutes and rules - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services	01470			

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01470	Continued From page 44 - A review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500			

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01500	Continued From page 45 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01500			

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01500	Continued From page 46 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-F had a hire date of February 18, 2020, to provide direct care services to the licensee's residents. On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F's record included an Educare (the licensee's online training curriculum) transcript indicating the last training topic completed was dated June 1, 2024. ULP-F's employee record included a document labeled Skills Fair dated June 17, 2025, and indicated training subjects to include Home Care Bill of Rights (need to review/train staff regarding Assisted Living Bill of Rights), resident complaints, two hours of dementia related training, Vulnerable Adult training, disaster planning/emergency preparedness, review of agency's policies related to Assisted Living statutes, blood borne pathogens/TB (tuberculosis), and infection control; however, the training lacked the required annual training including: - Assisted Living Bill of Rights - effective approaches to use to problem solve when working with resident's challenging	01500			

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01500	Continued From page 47 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - principles of person-centered planning/service delivery. On September 24, 2025, at 1:55 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware the above listed training topics were missing from the annual Skills Fair Training for the staff. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment. The following training elements MUST be included every 12 months to all staff who performs direct care services: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - 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 - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De-	01540			

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01540	Continued From page 48 (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two 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 two of two employees (unlicensed personnel (ULP)-F and ULP-J) received the required amount of dementia, mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01540			

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01540	Continued From page 49 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 provided services under an Assisted Living Facility with Dementia Care license. During the entrance conference on September 22, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware of the contents of the employee record. ULP-F ULP-F had a hire date of February 18, 2020, to provide direct care services to the licensee's residents. On September 23, 2025, at 7:05 a.m., the surveyor observed ULP-F assist R2 with washing his face, complete a blood sugar check, and set up and administer oral medications and insulin injection. ULP-F's employee record lacked evidence she completed two hours of mental illness and de-escalation training as required. ULP-J ULP-J had a hire date of February 26, 2025, to provide direct care services to the licensee's residents. On September 23, 2025, at 10:00 a.m., the	01540			

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01540	Continued From page 50 surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J's employee record lacked evidence she completed: - two hours of mental illness and de-escalation training as required; and - eight hours of dementia training within 80 working hours of the employment start date. On September 24, 2025, at 1:52 p.m., LALD/CNS-A stated, "I've not heard of it" when asked about the two hours required training related to mental illness and de-escalation for the licensee's employees and the need to have been completed by July 1, 2025. On September 26, 2025, at 12:00 p.m., LALD/CNS-A provided the surveyor with a training document named "De-escalation training" dated June 4, 2025, indicating the licensee's staff participated in a group de-escalation training provided by a hospice agency. ULP-F and ULP-J's signatures were included in the training roster. LALD/CNS-A stated the training was one hour in duration, not the required two hours. LALD/CNS-A further stated ULP-J had not completed her dementia training as assigned and had worked greater than 80 hours since her employment start date. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date, and	01540			

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01540	Continued From page 51 employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring	01620			

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01620	Continued From page 52 in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days from the previous assessment for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01620			

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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
01620	Continued From page 53 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 started receiving services from the licensee on April 1, 2022, with diagnoses including heart failure, type 2 diabetes with insulin dependence, prostate cancer and epilepsy. R2's Service Agreement dated August 8, 2025, indicated he received services including hospice, assistance with dressing, grooming, transfers, blood sugar checks, medications and insulin injections. On September 23, 2025, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-F assist R2 with washing his face, check his blood sugar, and administer oral medications and insulin. On September 23, 2025, at 2:00 p.m., the surveyor requested R2's last three comprehensive nurse assessments. On September 24, 2025, at 10:30 a.m., the surveyor received Comprehensive Assessments dated January 2, 2024, June 19, 2024, and April 18, 2025. On September 26, 2025, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was, "I'm now confused, I thought the assessment schedule was upon admission, 14 days and 90 days, then with change in condition. We do the assessment at admission, 14 days, then 90 days one time,	01620			

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01620	Continued From page 54 annually, and with a change in condition. Doing a comprehensive assessment every 90 days is a lot." LALD/CNS-A further stated she would look to see if she had other assessments. On September 26, 2025, at 12:00 p.m., LALD/CNS-A provided the surveyor with the following comprehensive assessments and stated they were in the electronic medical record (EMR) system but had not been signed by her until just now (during survey), thus others who assisted with record capture didn't see them: - assessment dated September 22, 2024, (signed September 26, 2025) - assessment dated July 29, 2025, (signed September 26, 2025) - assessment dated September 21, 2025, (signed September 26, 2025) R3 R3 began services on May 2, 2022, with diagnoses including Alzheimer's disease, heart disease, and kidney failure. R3's Service Agreement dated September 25, 2025, (during survey), included services of hospice, assistance with bathing, dressing, feeding, medication administration, bed mobility, and transfers with Hoyer lift (mechanical lift). On September 23, 2025, at 9:30 a.m., the surveyor observed ULP-D and ULP-I assist R3 with transfer from her wheelchair to her bed with use of a Hoyer lift for an incontinence brief change and then transferred her to her recliner. On September 23, 2025, at 2:00 p.m., the surveyor requested R2's last three	01620			

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01620	Continued From page 55 comprehensive nurse assessments. On September 24, 2025, at 10:30 a.m., the surveyor received Comprehensive Assessments dated June 4, 2024, December 1, 2024, (signed September 24, 2025), and June 25, 2025, (signed September 24, 2025). On September 26, 2025, at 11:20 a.m., LALD/CNS-A stated her confusion with the RN comprehensive assessment schedule and stated she would look for any others. She stated she has forgotten to sign many of the assessments after completing them. On September 26, 2025, at 12:00 p.m., LALD/CNS-A provided the surveyor with R3's comprehensive assessment dated March 10, 2025, (signed on September 26, 2025). R4 R4 began services on July 7, 2018, with diagnoses of stroke, type 2 diabetes, and depression. R4's Service Agreement dated February 3, 2025, included services of hospice, assistance with dressing, bathing, toileting, medication administration, transfers with Hoyer lift, and Pure wick incontinence equipment. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift.	01620			

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01620	Continued From page 56 On September 23, 2025, at 2:00 p.m., the surveyor requested R2's last three comprehensive nurse assessments. On September 24, 2025, at 10:30 a.m., the surveyor received Comprehensive Assessments dated November 14, 2024, February 13, 2025, and May 19, 2025. On September 26, 2025, at 12:00 p.m., LALD/CNS-A provided the surveyor with R4's comprehensive assessment dated September 21, 2025, (signed September 26, 2025). R4's 90-day comprehensive assessment was due by August 17, 2025, and was 30 days late. LALD/CNS-A stated she was aware R4's comprehensive assessment was late. The licensee failed to ensure comprehensive assessments were completed (including signature/date) every 90 days as required. The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. Resident reassessment. Additionally, monitoring must be conducted no more than 14 calendar days after initiating services, on-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided.	01620			

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01620	Continued From page 57	01620			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for three of seven residents (R3, R11, R14).	01640			

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01640	Continued From page 58 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: R3 R3 began receiving services under the licensee's assisted living with dementia care license on services on May 2, 2022, with diagnoses including Alzheimer's disease, heart disease, and kidney failure. R3's Service Agreement dated September 25, 2025, (during survey), included services of hospice, assistance with bathing, dressing, feeding, medication, bed mobility, and transfers with Hoyer lift (mechanical lift). On September 23, 2025, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-I assist R3 with transfer from her wheelchair to her bed with use of a Hoyer lift for an incontinence brief change and then transferred her to her recliner. On September 25, 2025, at 10:00 a.m., the licensee provided the surveyor with R3's service agreement signed on September 25, 2025. (during survey). On September 26, 2025, at 11:00 a.m., licensed	01640			

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01640	Continued From page 59 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not sure why R3's Service Agreement was not signed and would look into it further. No further information/clarification was provided. R11 R11 began receiving services under the licensee's assisted living with dementia care license on November 26, 2024, with diagnoses including dementia with psychotic disturbance, and type 2 diabetes. The licensee provided the surveyor with R11's unsigned, Service Agreement indicating an effective date of September 26, 2025 (during survey), and included the services of assistance with dressing, bathing, toileting, blood sugar checks, compression stockings R11 was currently hospitalized following a fall event on September 19, 2025. On September 26, 2025, at 11:05 a.m., housing manager (HM)-M stated he was uncertain why R11's Service Agreement was not signed by R11, R11's designated representative, or a facility representative. R14 R14 began receiving services under the licensee's assisted living with dementia care license on March 29, 2022, with diagnoses including Alzheimer's disease and depression. The licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing,	01640			

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01640	Continued From page 60 and ambulation. R14's Service Agreement lacked the service of medication administration. On September 23, 2025, at 7:45 a.m., the surveyor observed ULP-D setting up R14's morning medications. The licensee failed to ensure R3, R11, and R14's Service Agreements were signed by the residents/designated representatives, or by a facility representative as required. On September 26, 2025, at 12:00 p.m., LALD/CNS-A stated she was not sure/aware why R14's Service Agreement was not signed and not sure why the service of medication administration was not included in R14's Service Agreement. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by [licensee's name] 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 (21) days	01640			
01650 SS=D	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;	01650			

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01650	Continued From page 61 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of seven residents (R14) who received 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 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	01650			

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01650	Continued From page 62 situation has occurred only occasionally). The findings include: R14 began receiving services under the licensee's assisted living with dementia care license on March 29, 2022, with diagnoses including Alzheimer's disease and depression. The licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing, and ambulation. R14's Service Agreement lacked the service of medication administration. On September 23, 2025, at 7:45 a.m., the surveyor observed ULP-D setting up R14's morning medications. R14's MAR dated September 2025, indicated she received scheduled medications including one for constipation, one supplement, one for blood pressure, and one for depression. R14's MAR also indicated as needed (PRN) medications including one for mild pain, one for significant pain, two for constipation, one for heartburn, one for cough, one for dermatitis, one for agitation, one for skin itching/rash, one for anxiety, one for excessive secretions, one for chest pain and one for nausea/vomiting. The licensee failed to ensure medication administration was part of R14's Service Agreement. On September 26, 2025, at 12:00 p.m., licensed assisted living/clinical supervisor (LALD/CNS)-A stated she was not sure why the service of	01650			

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01650	Continued From page 63 medication administration was not included in R14's Service Agreement. The licensee's Service Plan policy dated August 1, 2021, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan includes the following: - a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; - the fees for services and the frequency of each service according to the resident's current review or assessment and resident preferences; and - the identification of the staff or categories of staff who will provide the services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760			

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01760	Continued From page 64 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 two of seven residents (R2, R1), and failed to ensure all medications were transcribed with clear instruction for two of seven residents (R14, R12). 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: MEDICATION ADMINISTRATION AS ORDERED R2 R2 started receiving services from the licensee on April 1, 2022, with diagnoses including heart failure, type 2 diabetes with insulin dependence, prostate cancer and epilepsy. R2's Service Agreement dated August 8, 2025, indicated he received services including medication management/administration. On September 22, 2025, at 2:35 p.m., the surveyor and unlicensed personnel (ULP)-C	01760			

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01760	Continued From page 65 reviewed the contents of the assisted living's second floor medication cart. The surveyor observed several tubes of diclofenac gel (topical pain medication) as stored in various resident's treatment bins. ULP-C stated R2's diclofenac was just as needed (PRN). When asked how the diclofenac was administered, ULP-C stated, "I just squirt some on my gloved finger and apply it where it needs to go." After the surveyor showed ULP-C the measuring tool (a plastic card used to accurately measure the diclofenac) found in each resident's diclofenac box, ULP-C stated, "oh yeah, that's how we do it." R2's medication administration record (MAR) dated September 2025, indicated he received one medication for gas relief, one for seizure control, one supplement, one for severe pain, one for acid reflux, three for constipation, one for prostate enlargement/urinary retention, two for excessive fluids due to heart failure, one for mild pain, one for infection prevention, one for agitation, one for anxiety, one for nausea, one for low blood sugar, one injection for diabetes, two supplements, one topical pain medication, one topical powder and cream for skin rash, and one eye drop for dry eyes. R2's signed provider's orders dated August 13, 2025, indicated diclofenac 1% gel, apply 2 grams (gm) to left knee and ankle three times daily as needed (PRN) for pain. R1 R1 began receiving services under the licensee's Assisted Living with Dementia Care license on June 13, 2024, with diagnoses including Alzheimer's disease, depression, and heart	01760			

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01760	Continued From page 66 disease. R1's Service Agreement dated August 8, 2025, included the service of medication management/administration. On September 22, 2025, at 4:15 p.m., the surveyor and ULP-E reviewed the licensee's secured unit second floor medication cart. The surveyor observed several tubes of diclofenac gel in the cart for various residents stored in their "treatment bins". The surveyor did not observe any measuring tools in any treatment bins or in the cart. The surveyor asked ULP-E how she measured R1's diclofenac gel. ULP-E stated she sometimes used a plastic measuring cup and attempted to demonstrate with a disposable measuring cup found on the medication cart; however, the measuring cup lacked a "gram" measurement. ULP-E stated she then usually "estimated" the amount to use. R1's MAR dated September 2025, indicated she received one medication for blood thinning/heart health, one for blood pressure, two for mild pain, one for depression, one for constipation, two for angina (heart pain), one for thyroid, one for sleep, one for nausea/vomiting, one for loose stools, one for agitation/restlessness, one for severe pain/shortness of breath, one supplement, one topical pain medication, one eye drop for glaucoma, and one eye drop for dry eyes. R1's signed provider's orders dated August 18, 2025, indicated diclofenac 1% topical gel for pain, apply 2 gm to right wrist and toes. The licensee failed to ensure the ULP were	01760			

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NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947			
(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 67 accurately measuring diclofenac to residents as ordered. On September 26, 2025, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "What is happening I think, is the ULP think they know how much the dose is and just go with that." MEDICATION RECORD/TRANSCRIPTION R14 R14 began receiving services under the licensee's assisted living with dementia care license on March 29, 2022, with diagnoses including Alzheimer's disease and depression. The licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing, and ambulation. R14's Service Agreement lacked the service of medication administration. On September 23, 2025, at 7:45 a.m., the surveyor observed ULP-D setting up morning medications. The surveyor observed an unlabeled tube of diclofenac gel (topical pain medication) in R14's medication bin. ULP-D stated she was not sure how often R14 used the diclofenac gel and was unable to find it on R14's medication administration record (MAR). R14's MAR dated September 2025, indicated scheduled medications including one dietary supplemental drink, one oral medication for constipation, one supplement, one for high blood pressure, one for depression, and one for psychosis. Furthermore, R14's MAR indicated	01760			

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01760	Continued From page 68 PRN medications including one for mild pain, one for heartburn, one for constipation, one for cough, one for agitation, one for oral secretions, one for anxiety, one for constipation, one for chest pain, one for nausea/vomiting, one for severe pain, one topical cream for dermatitis, and one topical cream for itching/irritated skin. On September 25, 2025, at 9:12 a.m., the surveyor requested R14's signed provider's orders for medications. On September 26, 2025, at 10:30 a.m., LALD/CNS-A stated she was not sure where R14's medication orders were but would look into it further. She further stated she was not sure why R14's diclofenac gel was not labeled nor on R14's MAR, since it was in her treatment bin and would look into it further. No further orders or information was provided. The licensee failed to ensure all medications were transcribed to R14's MAR. R12 R12 began receiving services under the licensee's assisted living with dementia care license on May 21, 2022, with diagnoses including vascular dementia and type 2 diabetes. R12's Service Agreement dated May 20, 2025, included the service of medication management/administration. On September 22, 2025, at 4:15 p.m., the surveyor and ULP-E reviewed the licensee's secured unit's second floor medication cart. The surveyor observed several tubes of diclofenac	01760			

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01760	Continued From page 69 gel in the cart for various residents stored in their "treatment bins". When asked where R12's diclofenac gel was applied, ULP-E stated she "was not sure, probably just where she [R12] asks for it." R12's MAR dated September 2025, included diclofenac 1% gel, apply 2 gm to skin four times daily as needed for pain. R12's signed provider's orders dated September 17, 2025, indicated diclofenac 1% gel to skin four times daily as needed for pain. R12's orders and MAR lacked a clear indication to where on R12's body, the diclofenac gel was to be applied. On September 26, 2025, at 10:35 a.m., LALD/CNS-A stated she was not certain where R12's diclofenac gel was to be applied and would need to investigate further. No further information was provided. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated August 1, 2021, indicated [licensee name] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all	01760			

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01760	Continued From page 70 prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760			
01820 SS=E	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 current written or electronically recorded prescriptions were obtained for all medications the provider managed for three of six residents (R3, R4, R14). 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:	01820			

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01820	Continued From page 71 R3 R3 began services on May 2, 2022, with diagnoses including Alzheimer's disease, heart disease, and kidney failure. R3's Service Agreement dated September 25, 2025 (during survey), included services of hospice, assistance with bathing, dressing, feeding, medication administration, bed mobility, and transfers with Hoyer lift (mechanical lift). On September 23, 2025, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-I assist R3 with transfer from her wheelchair to her bed with use of a Hoyer lift for an incontinence brief change and then transferred her to her recliner. R3's medication administration record (MAR) dated September 2025, indicated scheduled medications including one medication for seizure control, one for constipation, one eye drop for dry eyes. The MAR also indicated the following as needed (PRN) medications: one antacid for heartburn, one nasal gel for nasal congestion, one sunscreen, one barrier skin cream, two medications for cough, one for agitation, one topical cream for irritated/itchy skin, one medication for significant pain, and one for loose bowels. R3's signed hospice provider orders dated September 15, 2025, indicated active orders for: -divalproex 125 milligrams (mg), on capsule two times daily for seizure control; -polyvinyl alcohol 1.4% solution, place one drop into each eye three times daily for dry eyes; -polyethylene glycol (MiraLAX), 17 grams (gm)	01820			

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01820	Continued From page 72 every day for constipation; -Ayr Saline gel, place two drops in each nostril every hour as needed for nasal congestion; -Nystatin 100,000 units/gram topical powder, apply small amount to red skin folds as needed daily; -lorazepam 0.5 mg, give 1 tablet by mouth every two hours as needed for anxiety; -hydromorphone 1 milligram/milliliter (mg/ml), give 1 ml every two hours as needed for pain; -Senna-s stool softener 8.6-50 mg, give on tablet orally twice daily as needed; and -haloperidol 2 mg/ml, give 0.5 ml under the tongue every four hours as needed for agitation The following medications were noted on R3's September MAR, however the licensee only provided a signed order dated September 25, 2025, (during survey) to discontinue these medications: -discontinue calcium antacid 1 tablet every 2 hours as needed for indigestion; -discontinue banana boat topical for sunburn prevention; -discontinue cavilon barrier cream as needed for skin irritation -discontinue guaifenesin 10 milliliters every 4 hours as needed for cough; and -discontinue Halls cough 1 ounce (oz), one cough drop every 4 hours as needed for cough The licensee failed to provide original or updated annual orders for the above listed (now discontinued) medications. On September 26, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not at the facility the day before and did not provide the signed	01820			

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01820	Continued From page 73 orders as sent and dated but would look into it further. No further information was provided. R4 R4 began services on July 7, 2018, with diagnoses of stroke, type 2 diabetes, and depression. R4's Service Agreement dated February 3, 2025, included services of hospice, assistance with dressing, bathing, toileting, medication administration, transfers with Hoyer lift, and Pure wick incontinence equipment. On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-J and ULP-H assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. ULP-J stated R4 had already received her morning medications. R4's MAR dated September 2025, indicated scheduled medications including one for high blood pressure and irregular heartbeat, one for the heart, one for constipation, one for depression and one skin cream, . R4's MAR also indicated PRN medications including two for constipation, one for anxiety, one for agitation, one for significant pain, one for loose BM, one for excessive secretions, one for cough, one for allergies, one for mild pain, one for heartburn, one sunscreen, one topical cream for pain, one for skin irritation, one topical ointment for minor wound, and one topical powder for skin redness.	01820			

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01820	Continued From page 74 R4's signed provider's orders dated September 15, 2025, indicated active orders for: - acetaminophen 325 mg, two tablets every 6 hours as needed for mild pain; - aspirin 325 mg, one tablet by mouth daily for heart health; - Claritin 10 mg, give one tablet daily as needed for allergies; - cherry cough drops, 1 lozenge hourly as needed for cough; - clobetasol 0.05% topical ointment, apply 1 centimeter to labia area twice daily for rash; - guaifenesin AC 10 mg, 100 mg/5 ml, give 10 ml every 4 hours as needed for cough; - haloperidol 2 mg/ml, give 1 mg every 4 hours as needed for agitation; - levsin 0.125 mg, give 1 tablet orally every 4 hours as needed for excessive secretions; - lorazepam 2 mg/ml, give 0.5 mg every 4 hours as needed for anxiety; - metoprolol succinate ER, 25 mg, give 1 tablet every day; - Morphine sulfate 100 mg/5 ml oral solution, give 10 mg orally every 4 hours as needed for significant pain; - Senna lax 8.6 mg, give 1 tablet orally daily for constipation; and - sertraline 100 mg, give 1 tablet orally daily for depression -R4's record lacked evidence of original or annually updated signed provider orders for the following medications: - triple antibiotic ointment, apply to minor wounds daily as needed - Nystatin 100,00 units/gram powder, apply topically to areas of skin/fold with yeast appearance twice daily; - milk of magnesia give 30 ml orally daily as	01820			

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01820	Continued From page 75 needed for constipation; - loperamide 2 mg capsules, give 1 capsule by mouth after each diarrhea stool as needed. maximum 8 capsules/day; - Halls cough lozenge, give 1 cough drop in the cheek every 4 hours as needed for sore throat; - antacid suspension, give 30 ml orally every 4 hours as needed for heartburn; - banana boat sunscreen apply topically at least 30 minutes prior to sun exposure On September 26, 2025, at 10:56 a.m., LALD/CNS-A stated R4 was on hospice, and needed to look further for the missing signed orders. No further orders were provided. R14 R14 began receiving services on March 29, 2022, with diagnoses including Alzheimer's disease and depression. The licensee provided the surveyor with R14's unsigned, Service Agreement with an effective date of September 26, 2025, and included the services of assistance with bathing, dressing, and ambulation. R14's Service Agreement lacked the service of medication administration. On September 23, 2025, at 7:45 a.m., the surveyor observed ULP-D setting up R14's morning medications. The surveyor observed an unlabeled tube of diclofenac gel (topical pain medication) in R14's medication bin. ULP-D stated she was not sure how often R14 used the diclofenac gel and was unable to find it on R14's medication administration record (MAR). R14's MAR dated September 2025, indicated	01820			

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01820	Continued From page 76 scheduled medications including one dietary supplemental drink, one oral medication for constipation, one supplement, one for high blood pressure, one for depression, and one for psychosis. Furthermore, the MAR indicated PRN medications including one for mild pain, one for heartburn, one for constipation, one for cough, one for agitation, one for oral secretions, one for anxiety, one for constipation, one for chest pain, one for nausea/vomiting, one for severe pain, one topical cream for dermatitis, and one topical cream for itching/irritated skin. R14's MAR lacked evidence of diclofenac gel as found in her medication bin. On September 25, 2025, at 9:12 a.m., the surveyor requested R14's signed provider's orders for medications. R14's record lacked signed medication orders; furthermore, her record lacked an order for the diclofenac gel found in her medication bin. On September 26, 2025, at 10:30 a.m., LALD/CNS-A stated she was not sure about where R14's medication orders were located but would look into it. No further information was provided. The licensee failed to ensure R3, R4, and R14's records included original or updated signed provider's orders for all medications. The licensee's Medications and Treatment Orders dated August 1, 2021, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. An order for medication or	01820			

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01820	Continued From page 77 treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure stored medications were not expired for four of 59 residents (R6, R8, R9, R10) receiving medication administration. Additionally, the licensee failed to ensure all medications bore a proper label and included an open date for time sensitive medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890			

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01890	Continued From page 78 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: EXPIRED MEDICATIONS On September 22, 2025, at 2:10 p.m., the surveyor and unlicensed personnel (ULP)-C reviewed the contents of the assisted living second floor medication cart. The following medications were found to be expired: - R6 Stioloto Respimat 25 micrograms (mcg); label indicated discard by September 16, 2025; - R8-Alcon tears 0.5%; label indicated discard by March 25, 2025; - R9 benzonatate 200 milligrams (mg) label indicated discard by November 30, 2024, with three tablets remaining, and a second bubble pack with a label indicating discard by June 3, 2025, with 30 tablets remaining - R10 benzonatate 100 mg label indicated discard by February 12, 2025, with one tablet remaining, and a second bubble pack indicating discard by April 5, 2025, with 24 tablets remaining. - R10 Meclizine 25 mg label indicated discard by January 17, 2025, with five tablets remaining. OPEN DATES On September 22, 2025, at 2:10 p.m., the surveyor and ULP-C reviewed the contents of the assisted living second floor medication cart. The following medications were found to lack an opened date: - R2 lispro insulin 100 units/milliliter (u/ml), no	01890			

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01890	Continued From page 79 open date - R5 Systane eye drops-one opened bottle - R7 Combivent Respimat 20 mcg/100 mcg; discard 90 days after cartridge inserted-no open date indicated - R8 Refresh eye drops; two open bottles On September 22, 2025, at 4:15 p.m., the surveyor and ULP-E reviewed the contents of the licensee's second floor secured unit medication cart and noted the following medications lacked an open date; - R11 glargine insulin 100 units/milliliter- no open date - R12 Combivent Respimat inhaler-discard 90 days after cartridge inserted; no open date NO LABEL On September 22, 2025, at 4:15 p.m., the surveyor and ULP-E reviewed the contents of the licensee's second floor secured unit medication cart and noted the following medications lacked a proper label: - R11 glargine insulin 100 units/milliliter-no label - R12 Combivent Respimat inhaler -no label On September 23, 2025, at 7:50 a.m., the surveyor and ULP-D reviewed the contents of the licensee's first floor memory care medication cart and noted the following medications lacked a proper label: -R14 diclofenac gel On September 26, 2025, at 10:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the care coordinator oversaw medication cart review, knew the requirements, and had said the carts were reviewed. She further stated the carts needed to	01890			

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NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947			
(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
01890	Continued From page 80 be monitored better. Systane manufacturer's instructions dated September 12, 2024, indicated generally, once opened, most Systane eye drops are safe to use for up to one month. Glargine manufacturer's instructions dated 2022, indicated after 28 days throw opened insulin pen away even if insulin remained in the pen. The licensee's Medication Storage policy dated August 1, 2021, indicated When medications are managed and stored by [facility name], medications will be kept securely locked and stored per manufacturer's directions. No further information was provided. Medications will be stored consistent with manufacturer's recommendations TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950			

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01950	Continued From page 81 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R2) with blood sugar monitoring. 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 started receiving services from the licensee on April 1, 2022, with diagnoses including heart failure, type 2 diabetes with insulin dependence, prostate cancer and epilepsy. R2's Service Agreement dated August 8, 2025, indicated he received services including hospice, assistance with dressing, grooming, transfers, blood sugar checks, medications and insulin injections.	01950			

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01950	Continued From page 82 On September 23, 2025, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-F assist R2 with washing his face, check his blood sugar, and administer oral medications and insulin. R2's signed prescriber's orders dated lispro 75/25 units/milliliter (u/ml), inject 6 units daily with morning and evening meal. Hold morning insulin if blood sugar is less than 100, or if patient is not going to eat a meal. The order further indicated blood sugar check to be completed daily in the morning before breakfast. R2's medication administration record (MAR) dated September 2025, indicated lispro 75/25 units/milliliter (u/ml), inject 6 units daily with morning and evening meal. Hold morning insulin if blood sugar is less than 100. The MAR further indicated test blood sugar before administering morning insulin. The licensee's RN did not provide direction regarding the management of R2's blood sugar parameters and when the ULP should notify a nurse. On September 26, 2025, at 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not included blood sugar parameters or when the ULP needed to contact nursing for residents who had blood sugar checks but would initiate that practice. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated When administration of medications or treatment/therapy is delegated or assigned to	01950			

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01950	Continued From page 83 unlicensed personnel, [licensee name] will ensure that the registered nurse has: - instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic	02110			

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02110	Continued From page 84 medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and the resident's legal and designated representative at the time of move-in for four of four residents (R1, R2, R3, R4). 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 the residents). The findings include: The licensee had an assisted living with	02110			

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02110	Continued From page 85 dementia care license effective December 1, 2024. R1, R2, R3, and R4's records lacked evidence of receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On September 26, 2025, at 11:55 a.m., housing/marketing manager (HM)-M stated he managed the licensee's contract and Service Agreement paperwork/signatures and was	02110			

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02110	Continued From page 86 unaware of the requirement to provide the dementia related policies and procedures to all residents of the facility at the time of move in. The licensee's Assisted Living with Dementia Care Additional Required policies dated August 1, 2021, indicated because [licensee's name] had an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must include additional dementia related policies. In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110			
02170 SS=D	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: (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	02170			

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02170	Continued From page 87 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 interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and develop an individualized activity plan for one of two residents (R4) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02170			

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02170	Continued From page 88 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living with dementia care license effective December 1, 2024, through November 30, 2025. R4 began receiving services from the licensee on July 7, 2018, with diagnoses including cerebrovascular disease (disease process affecting the brain/blood vessels), history of stroke with left sided weakness/hemiparesis, type 2 diabetes, and depression, and received services in the licensee's secured memory care unit. On September 26, 2025, at 11:15 a.m., activities director (AD)-N provided the surveyor with R4's monthly activities participation record for the previous 12 months; however, R4's record lacked an evaluation of the following: - 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. In addition, R4's record lacked the development of an individualized activity plan. On September 26, 2025, at 11:15 a.m., activities director (AD)-N stated she was relatively new to the role and was unable to locate an activities evaluation and individualized activity plan for R4.	02170			

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02170	Continued From page 89 No further information 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 observation, interview, and record review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for one of two residents (R4). This practice resulted in a level two violation (a	02180			

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02180	Continued From page 90 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: R4 began services on July 7, 2018, with diagnoses of stroke, type 2 diabetes, and depression. R4's Service Agreement dated February 3, 2025, included services of hospice, assistance with dressing, bathing, toileting, medication administration, transfers with Hoyer lift, and Pure wick incontinence equipment. On September 23, 2025, at 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R4 to transfer to her bed with a Hoyer lift (mechanical lift). ULP-J assisted with R4's incontinence brief change, redressing, and transferred R4 back to her Broda chair (specialized wheelchair) via Hoyer lift. R4's nurse progress note dated August 18, 2025, indicated "Resident has had to have increase in dose of lorazepam daily lately due to her behaviors. Staff reports she has been rocking trying to get out of chair and stand. She gets upset with cares. Lorazepam has helped these behaviors." R4's Comprehensive Assessment dated May 19, 2025, and Comprehensive Assessment dated	02180			

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02180	Continued From page 91 September 21, 2025, (signed September 26, 2025,) both labeled as a Change of Condition Evaluations for aggressive behaviors and increased pain in buttocks and legs indicated the following information as noted on page five of the assessment: Indicate conditions that affect the resident's responsive behaviors within the last 6 months: D. Assaultive Behavior: Verbal (describe) : Swearing at staff. verbal threats F. Delusions (describe): Thinks husband sitting next to her. Dementia H. Hallucinations (describe) : Thinks she sees people in her room L. Resistive to Care (describe): gets upset when trying to get her to meals and toilet sometimes. can get angry with staff. tells them to leave room. Additionally, the assessment directed "indicate any assistance needed to support responsive behaviors" and included the response A. N/A (not applicable) The evaluation/care plan/service agreement lacked non-pharmacological interventions to implement for behavior management regarding R4's increase in agitation. On September 26, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the residents needed to have non-pharmacological interventions in place for staff to manage resident aggression and behaviors and needed to update R4's care plan to reflect the interventions. The licensee's ALDC Behavioral Symptoms, Interventions & Nonpharmacological Approaches	02180			

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02180	Continued From page 92 policy dated August 1, 2021, [licensee name] will 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. Behavioral symptoms that require outside consultation or acute care placement will be identified and acted upon. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02180			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. 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	03090			

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03090	Continued From page 93 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Upon entrance to the facility on September 22, 2025, at 11:00 a.m., the surveyor observed the front entrance and entryway of the facility. No electronic monitoring signage was observed. On September 22, 2025, at 12:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the required electronic monitor signage was usually posted at the front door/foyer area, and confirmed it was now missing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Rochester District Office
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Food & Beverage Inspection Report

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Establishment Info	License Info	Inspection Info
SPRINGBROOK VILLAGE LACRESCENT 1384 COUNTY ROAD 25 La Crescent, MN 55947 Houston County Parcel: Phone:	License: HFID 33651 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1045251066 Inspection Type: Full - Single Date: 9/22/2025 Time: 11:45 am Duration: minutes Announced Inspection: No <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 2</u> <u>Delivery: Emailed</u>

New Order: 2-100 Supervision

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

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

COMMENT:

No current CFPM on staff. Emailed information

Comply By: 10/22/2025 Originally Issued On: 9/22/2025

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

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

COMMENT: Both of the Turbo Air cold storage units were observed holding product above 41F. Director reduced temperature at time of inspection

Comply By: Complied On Site Originally Issued On: 9/22/2025

New Order: 4-100 Equipment Construction Materials

4-101.19 Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

COMMENT:

Laminate cupboards located beneath the water/ice dispenser were observed pitted/chipped and raw wood showing.

Discussed getting these replaced with smooth and easily cleanable units.

Comply By: 9/22/2026 Originally Issued On: 9/22/2025

Food & Beverage General Comment

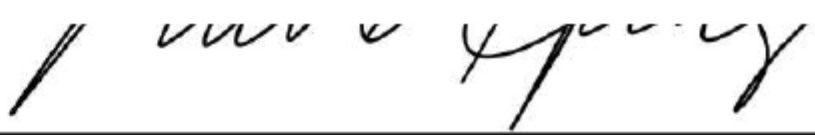
Fire Ext/ Ansul System serviced 09/2025

Main Backflow Insp - 05/2025

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 Rochester District Office inspection report number F1045251066 from 9/22/2025

Tom Bauer
Food Director



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