Electronically Delivered

July 8, 2025

Licensee
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL32070016

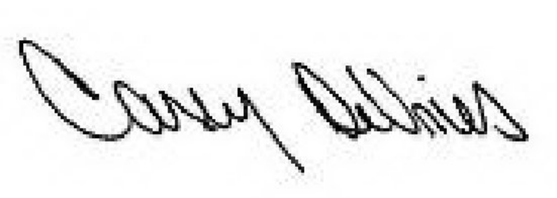
Dear Licensee:

On June 18, 2025, the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders from the survey completed on April 1, 2025. This follow-up survey verified that the agency is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

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April 30, 2025

Licensee
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL32070016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - - $3,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

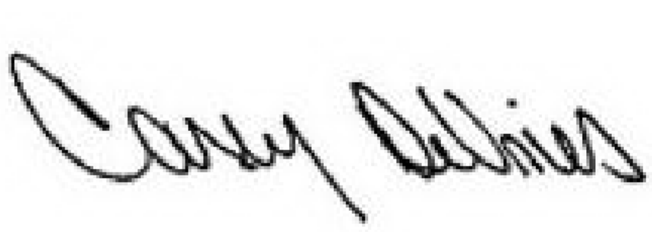
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(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: SL32070016-0 On March 31, 2025, through April 1, 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 three residents, all of them received services under the Assisted Living license. An immediate correction order was identified on March 31, 2025, issued for SL32070016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. *Please note correction made to scope and severity language of immediate order issued on	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

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0 000	Continued From page 1 March 31, 2025, tag identification 1290.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480		

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0 480	Continued From page 2 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) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 1, 2025, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 3 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		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement, maintain, and document a quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 580		

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0 580	Continued From page 4 the residents). The findings include: On April 1, 2025, at 12:52 p.m., licensed assisted living director (LALD)-D stated they had not been documenting quality management activities, but they did do them. The licensee's 2.31 Quality Management Project policy dated July 21, 2024, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 5 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 interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B). 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 the residents). The findings include: ULP-B was hired on September 20, 2019, to provide direct care and services to residents. ULP-B's employee record lacked the required documentation for the following: - annual performance evaluation. On April 1, 2025, at 1:00 p.m., licensed assisted living director (LALD)-D stated they filled out the performance evaluation form, but they did not sit down with the employees to discuss the evaluation. The licensee was unable to produce a	0 650		

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0 650	Continued From page 6 filled-out performance evaluation form in the employees record for any employee. LALD-D stated they had not completed any performance evaluation for any employee in the past. The licensee's 4.05 employee records policy indicated the licensee will keep an employee record for all paid employees. Employee records will be kept up-to-date and confidential. Employee records for each person will include: - evidence of current professional licensure, registration or certificate, if required; - records of all training and in-service education required and/or provided including record of competency testing as required; - current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; - documentation of annual performance reviews that identify areas of improvement needed and training needs; - for individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings; - documentation of a competed criminal background study; and - verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 7 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 660		

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0 660	Continued From page 8 ULP-A was hired on March 6, 2025, to provide direct cares and services to residents. ULP-A's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated October 8, 2021, with a completed health history and baseline TB symptom screening for ULP-A. The Baseline TB Screening Tool indicated a negative TST result for a two-step TST read on October 10, 2021, and October 24, 2021, for TST's administered on October 8, 2021, and October 22, 2021, respectively. ULP-A's employee record also included QuantiFERON TB gold plus negative results dated January 9, 2023, and another QuantiFERON TB gold plus negative result dated September 24, 2022. ULP-A's employee record lacked the baseline TB symptom screening, a completed health history, and TST or other evidence of TB screening such as a blood test, dated within 90 days before hire. On April 1, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated they were aware that TB screening was supposed to be done within 90 days before hire. CNS-C stated they thought ULP-A had enough documentation to satisfy the TB requirement after talking to licensed assisted living director (LALD)-D. On April 1, 2025, at 1:05 p.m., LALD-D stated they thought the above-mentioned results on file were good enough. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.	0 660		

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0 660	Continued From page 9 The Minnesota Department of Health document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's 8.16 Tuberculosis Screening policy dated July 21, 2024, 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 . 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.	0 660		

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0 660	Continued From page 10 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. 5. Staff should be screened for signs and symptoms on an annual basis. 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	0 680		

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	32070	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

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0 680	Continued From page 11 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan dated July 16, 2024, lacked the following content: - program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - methods for sharing information; - sharing information on occupancy/needs; and - quarterly review of the missing resident plan. On April 1, 2025, at 12:47 p.m., licensed assisted living director (LALD)-D stated they do reviews annually, and they had not looked at the EP plan since July. LALD-D stated missing resident policy	0 680		

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0 680	Continued From page 12 was reviewed annually or as needed. LALD-D further stated they learned about the EP plan on the last survey, and they were working on it, but had not completed it. The licensee's 2.01 Policies and Procedures Overview indicated the licensee shall maintain an Emergency Plan describing our all-hazards approach to emergency management. The Emergency Plan guidelines would be developed and made widely available to all staff. This plan would be maintained in accordance to state and federal guidelines would be reviewed and updated annually. The Emergency Plan is Incident Command System (ICS) compliant. The licensee's 2.28 Missing Resident Plan dated July 21, 2024, indicated the licensee would review the missing resident policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota	0 775		

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0 775	Continued From page 13 Rules Chapter 7511. Cigarettes were not disposed of in a proper manner and discarded smoking materials were located on the rear porch and ground around the property. Egress routes from the property were not properly maintained and were obstructed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 1, 2025, from approximately 9:23 a.m. to 10:31 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour, the surveyor observed the following deficient conditions: Discarded smoking materials were located on the ground around the facility. Cigarettes were present in the rear yard and on rear porch. A shallow metal ashtray was provided as a receptable on the rear porch, but did not sufficiently contain discarded cigarettes as evidenced by the cigarette butts on nearby deck and ground. Cigarettes were also present in the front yard and near the front door of the property. LALD-D indicated that much of the accumulation of cigarettes was due to the weather and inability to clean the area. LALD-D acknowledged the accumulated discarded smoking materials and indicated they would provide adequate	0 775		

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0 775	Continued From page 14 receptacles for disposal and have cigarettes on the ground picked up. The front staircase on the Northeast side of the facility was blocked by stored furniture and items including a bag of concrete, pieces of gypsum board and a chair. These stairs were indicated as an emergency egress route but was not maintained free of obstruction so that it could be used to readily escape the building in an evacuation. LALD-D acknowledged the stored items and indicated that it is usually free of stored items, and indicated she understood that the stairs should not be blocked. All gates in the rear yard were obstructed, preventing proper egress to right of way. Evacuation plans indicated to exit via the rear yard and go through gates. The rear yard is fully fenced and the gates on the North and South side of the property were secured with chains or tied closed rendering them unopenable during the survey. LALD-D stated these gates were maintained closed and secured shut. There was another gate at the West end of the property which was unopenable due to overgrowth of trees and shrubs in the way. LALD-D stated they understood that none of the gates were operable, and that residents or staff would have trouble reaching the public right of way from the rear yard. The supplied smoke alarm in resident room 3 was over 10 years from manufacture date and should be replaced per manufacturer instructions. LALD-D confirmed that the smoke alarm would be replaced with a newer model. On April 1, 2025, the surveyor explained to LALD-D the requirements for proper disposal of	0 775		

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0 775	Continued From page 15 smoking materials and for maintaining egress routes. LALD-D stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780		

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0 780	Continued From page 16 failed to maintain the power supply of hardwired smoke alarm. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During a facility tour on April 1, 2025, from 9:23 a.m. through 10:31 a.m. licensed assisted living director (LALD)-D, the surveyor observed the following deficient conditions: No hardwired smoke alarm was present on the hardwired smoke alarm mount in resident room 5. Smoke alarms must be provided to maintain power supply. Hardwired alarms must be maintained and replaced with functional hardwired alarm. LALD-D stated they understood requirements and would have an interconnected hardwired alarm installed on the mount in resident room. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 17 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 1, 2025, from approximately 9:23 a.m. and 10:31 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour the surveyor observed the following: There was a significant amount of rodent feces under the sink and in the closet in the upper-level bathroom. LALD-D stated that an extermination company had been hired to treat for rodents due to known rodent issue, and that the facility had been cleaned, but acknowledged that some areas of the restroom had evidently not been cleaned of	0 800		

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0 800	Continued From page 18 droppings. There was old bars of soap and trash that was stuck in the gap between the bathtub and the sink vanity in the upper-level bathroom. The items stuck in this gap appeared to have been there for awhile and cloth items appeared discolored and degraded. The flooring leading into the kitchen was degraded and loose, with an area that was taped down to keep flooring in place. The uneven floor was not secure and could pose a tripping hazard. LALD-D indicated that a flooring company had recently done work on the flooring but not properly finished the job and that they had been contacted to come back and repair the damaged floor. A wooden gate by the rear staircase and door was not properly maintained. The gate was sagging in its mount and rubbed on the ground, making it hard to open and exit from the basement area. There was a hole in the upper-level bathroom door, and the door was damaged to the extent that it was difficult to open. A lighting fixture near the rear staircase and rear door on the first floor had shattered light bulbs and exposed fixtures which could pose a hazard. The fixture should be maintained in proper working order and broken light bulbs should be removed or replaced. A ground fault indicator (GFI) outlet in the kitchen near the bedroom hallway was not functional and was not supplied with power when tested. The GFI outlet appeared to be tripped and could not be reset. LALD-D stated the outlet would be	0 800		

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0 800	Continued From page 19 repaired or removed. An outlet cover was missing from an outlet in resident room 1. An outlet cover was missing from an outlet in resident room 3. An outlet cover was missing from an outlet in resident room 6. An outlet cover was missing from an outlet in resident room 7. An outlet cover was missing from an outlet near basement stairs. There was no window screen supplied on openable windows in resident room 2. LALD-D indicated the screen had been removed and would be replaced. The closet door in resident room 1 was off its track and laying to the side of the closet. Door assembly should be maintained in proper working order. The window trim and siding were loose and hanging around the front second story window of the facility. Window assembly and siding should be maintained in good condition and be securely attached to the building. There was a hole in the wall in the upper-level bedroom hallway. Walls should be maintained free of holes or damage. During the facility tour interview on April 1, 2025, LALD-D verified the above listed physical environment observation while accompanying on the tour.	0 800		

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0 800	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 April 1, 2025, at approximately 10:10 a.m., licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training. The licensee FSEP failed to include the following: The FSEP did not include employee actions to be taken in the event of a fire or similar emergency. Plans and procedures specific to evacuation from the facility should be provided in the FSEP for employees. The FSEP did not include fire procedures for residents. The FSEP should include plans for residents to follow during evacuation. The FSEP did not readily include procedures for	0 810		

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0 810	Continued From page 22 resident movement and evacuation with identification of unique and unusual resident needs. LALD-D was able to access this information on the computer, but the information took a significant amount of time to locate and required passwords to access. Information about resident needs during evacuation should be readily accessible and available to all employees. LALD-D indicated that information would be added to the FSEP binder. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year. The FSEP did not include any documentation of trainings provided to staff on the FSEP. LALD-D stated that this training was in development but had not been implemented yet. Staff should receive training on the FSEP upon hire and at least twice a year thereafter. The FSEP included evacuation maps that did not include location and room numbers for resident rooms. Resident rooms were not numbered, and no facility diagrams designated room numbers or other means of readily identifying resident rooms. During the record review and interview on April 1, 2025, LALD-D verified the above listed documents were absent from the FSEP. LALD-D stated that they understood requirements and would supplement the existing FSEP with missing information and documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01060	Continued From page 23	01060		
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	01060		

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01060	Continued From page 24 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted to the licensee on September 7, 2017. R1's diagnosis included diabetes, essential hypertension, depression, anxiety, mood disorder, edema, asthma, chronic obstructive pulmonary disease, and neuropathy. R1's signed Care Plan, dated April 24, 2024, indicated R1 received assistance for oral hygiene, skin care, medication administration, housekeeping, and blood glucose monitoring. R1's Inter Agency Transfer Form dated March 21, 2025, indicated R1 was sent to the hospital on March 16, 2025, and discharged from the hospital on Mach 21, 2025.	01060		

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01060	Continued From page 25 R1's record lacked evidence a written notice was provided 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; and - notification sent to the Office of Ombudsman for Long-Term Care for a hospital stay of more than four days. On April 1, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-C stated R1 was admitted to the hospital, and then R1 was sent to a rehabilitation facility before returning to the licensee on March 28, 2025. CNS-C stated they did not do the emergency relocation form for R1, and they did not notify the Ombudsman. CNS-C stated they were not aware that they needed to provide residents with an emergency relocation form and notify the Ombudsman if a resident has been relocated and has not returned to the licensee within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01290	Continued From page 26	01290		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of twelve employees (unlicensed personnel (ULP-A). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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:	01290		

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01290	Continued From page 27 ULP-A was hired on March 6, 2025, to provide direct care and services to residents. The licensee's Employee Schedule from March 30, 2025, through April 5, 2025, indicated ULP-A was scheduled to work on the following days: - nightshifts (11:00 p.m. to 7:00 a.m.) on March 30, 2025; - evening shifts (3:00 p.m. to 11:00 p.m.) on March 30, 2025, and April 4, 2025. ULP-A's employee record included a background study clearance dated February 28, 2022. The licensee's NetStudy Roster (web-based system for submitting background study requests to the Department of Human Services (DHS)) printed on March 31, 2025, did not include ULP-A's name on the list of employees whose BGS were cleared and affiliated to the licensee's health facility identification number (HFID). On March 31, 2025, at 10:56 a.m., licensed assisted living director (LALD)-D stated ULP-A stopped working for the licensee seven months ago and was rehired a couple weeks ago, and they forgot to run ULP-A's BGS again upon rehire. ULP-A's employee record lacked evidence the licensee submitted a BGS for ULP-A under the current assisted living license and affiliated to the current HFID #32070, upon rehire. The licensee's 4.02 Background Studies policy dated July 21, 2024, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No employee may provide direct services and have independent	01290		

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01290	Continued From page 28 direct contact with any residents until acceptable result of the background study have been received. The licensee will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01470 SS=E	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; (8) 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 29 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 interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (unlicensed personnel (ULP)-A, ULP-B).	01470		

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01470	Continued From page 30 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 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: ULP-A ULP-A was hired on March 6, 2025, to provide direct cares and services to residents. ULP-B ULP-B was hired on September 20, 2019, to provide direct cares and services to residents. ULP-A and ULP-B's employee records lacked evidence of orientation to assisted living regulations for the following topic: - overview of assisted living statutes; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On April 1, 2025, at 1:07 p.m., licensed assisted living director (LALD)-D stated they did assign required trainings to employees. On April 1, 2025, at 1:26 p.m., LALD-D stated they bought the Relias training software to include all the required training, but somehow some	01470		

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01470	Continued From page 31 training topics were still missing. The licensee's 5.01 Orientation of Staff and Supervisors and Contents policy dated July 21, 2024, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation topics will include the following: - an overview of the appropriate assisted living statutes and rules - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - 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 - a review of the types of assisted living services	01470		

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01470	Continued From page 32 the employee will be providing and the facility's category of licensure - the staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed - the facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services - the identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 33 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 34 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B) received all the required contents of annual training. 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 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-B was hired on September 20, 2019, to provide direct cares and services to residents. ULP-B's employee records included annual training last completed March 3, 2025. ULP-B's annual training record did not include the following required content: - principles of person-centered planning/service delivery. On April 1, 2025, at 1:30 p.m., licensed assisted living director (LALD)-D stated they thought the above-mentioned training was included in the list of annual training on Relias (online training program) and stated they did not know it was missing. The licensee's 5.06 Annual Required Staff Training dated July 21, 2024, indicated all staff	01500		

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01500	Continued From page 35 providing assisted living services would complete at least eight hours of education for each 12 months of employment and the education topics would include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 36 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the	01790		

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01790	Continued From page 37 medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01790		

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01790	Continued From page 38 The findings include: ULP-A ULP-A was hired on March 6, 2025, to provide direct cares and services to residents. ULP-B ULP-B was hired on September 20, 2019, to provide direct cares and services to residents. On April 1, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-C stated ULPs administered medications to residents for unplanned time away from home. CNS-C stated they had been told to include unplanned time away medication administration training to the list of required trainings, but it got missed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R3) with hospital bed rails.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on November 27, 2019. R3's diagnosis included cardiovascular accident with left sided weakness, blindness in right eye, and hypertension. R3's Care Plan, dated April 24, 2024, indicated R3 received assistance with oral hygiene, skin care, ambulation, transfer, and medication administration. On April 1, 2025, at 9:30 a.m., the surveyor observed a hospital bed rail on both sides of R3's hospital bed. R3's record included Bed Rail Use Assessment Form last reviewed January 20, 2025. The assessment included the following: - purpose and intention of the bed rail including consideration of whether the bed rail has the effect of being an improper restraint; - the resident's bed rail use/need assessment; - the resident's preferences; - entrapment zone measurements; and - physical inspection of the bed rail(s) and mattress for areas of entrapment, stability, and correct installation. R3's record lacked the following required items	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
02310	Continued From page 40 completed for bedrail use: - risk vs. benefits discussion (individualized to each resident's risks). On April 1, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-C stated they did not do the risk vs. benefit discussion for R3 and stated it was overlooked. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last reviewed December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: -Purpose and intention of the bed rail -Measurements -The resident's bed rail use/need assessment -Risk vs. benefits discussion (individualized to each resident's risks) -The resident's preferences -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 41 The licensee's 6.28 Side Rails policy dated July 21, 2024, indicated the resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/01/25*
Time: 12:00:00
Report: 1043251092

Food and Beverage Establishment Inspection Report

Location:
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038633
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124408001
ID #:

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

The following orders were issued during this inspection.

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO SPILL KIT OR CLEAN UP PROCEDURES AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN AT LEAST ONE WITHIN THE FACILITY. POSTER PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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

NO THIN PROBE THERMOMETER AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

4-500 Equipment Maintenance and Operation

4-502.11B ***** Priority 2 *****

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

PER STAFF, FOOD AND DISH MACHINE THERMOMETERS ARE NOT CALIBRATED. ADVISED STAFF TO CALIBRATE MONTHLY, WHEN DROPPED, OR WHEN BATTERIES ARE CHANGED. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

2-100 Supervision

2-102.12AMN

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

REPEAT FROM 7/18/22. NO CFPM EMPLOYED. ADVISED STAFF TO EMPLOY A FULL TIME EMPLOYEE AS A CFPM. INFO PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 157 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: BEEF PATTY
Temperature: 35 Degrees Fahrenheit - Location: THAWING
Violation Issued: No

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

Inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Per staff, leftover of foods cooked in house are discarded by end of day. Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment, wooden cabinetry, tiled floor, tiled back

splash, smooth & painted ceiling, and laminated countertops.

Facility has a Bosch Silence Plus 50 dBA dish machine. Sanitizing option on dish machine must always be used when running a cycle.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***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.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043251092 of 04/01/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Amber Karg

Signed:_____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us