



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 21, 2026

Licensee
Minnesota Wellness Center LLC
724 Robinwood Lane
Hopkins, MN 55305

RE: Project Number(s) SL34346016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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.

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - 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 \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Minnesota Wellness Center. **Please contact Jess Schoenecker at 651-201-3789 on or before February 7, 2026 to schedule the conference call.**

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/Bm5uQEpHVva>**. 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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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: SL34346016-0 On December 2, 2025, through December 5, 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; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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	
0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure there was at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between the licensed assisted living facility areas and another licensed area subject to another license type. The deficient practice 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 December 2, 2025, at 9:30 a.m., the surveyor arrived at the licensee's address at 724	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 100	Continued From page 3 Robinwood Lane, Hopkins, MN 55305. The surveyor observed the assisted living facility/building had two separate addresses of 724 Robinwood Lane, Hopkins, MN 55305, and 726 Robinwood Lane, Hopkins, MN 55305 under the same roof. The address at 726 Robinwood Lane, Hopkins, MN 55305, was located above the garage and immediately adjacent to the licensed assisted living facility. On December 2, 2025, at 12:19 p.m., licensed assisted living director (LALD)-C stated 726 Robinwood Lane, Hopkin, MN 55305, was used for their office only; and that address was also controlled by the owner of the assisted living license. On December 4, 2025, at 1:45 p.m., LALD-C stated 726 Robinwood Lane was regulated by Department of Human Services (DHS); and stated the space was used as an office. On December 4, 2025, at approximately 2:00 p.m., LALD-C allowed the surveyor access to an upper-level apartment noted to be above the assisted living facility garage located at 726 Robinwood Lane, Hopkins, MN 55305, which was under the same roof of the assisted living facility located at 724 Robinwood Lane, Hopkins, MN 55305. The surveyor observed personal items throughout the apartment. LALD-C stated they did not live in the apartment but did stay over night on occasion. LALD-C stated the space was licensed under DHS (which is not granted under chapter 144G). LALD-C stated the licensee did not know they needed to have a fire barrier separation between the two licensed areas. On December 5, 2025, at 3:38 p.m., during the exit conference, LALD-C stated the licensee had	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 100	Continued From page 4 100 percent control of the building; and the staff had a key to the apartment. LALD-C stated the owner had owned both properties. LALD-C stated the licensee would be contacting an attorney regarding this citation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services 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 interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 420	Continued From page 5 affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective September 1, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five 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 six was electronically signed by the owner (agent (A)-G) on February 21, 2025. As a result of this survey, the following orders were issued under 0100, 0420, 0460, 0480, 0510, 0660, 0680, 0730, 0775, 0780, 0800, 0810, 0990, 1040, 1060, 1320, 1330, 1440, 1490, 1500, 1530, 1610, 1650, 1710, 1760, and 2290, which	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 420	Continued From page 6 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents.	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 460	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 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 December 2, 2025, at 9:55 a.m., licensed assisted living director (LALD)-C confirmed the licensee did not have a system for their residents to summon staff 24/7. LALD-C stated the residents did not require it as the licensee had 24/7 awake staff. LALD-C stated the licensee provided safety checks on all residents, which one of them required a safety check every hour due to suicidal ideation. LALD-C stated if this is required by statute, then the licensee could install a system. On December 2, 2025, at 11:39 a.m., during the facility tour, the surveyor did not observe a system for residents to summon staff. On December 4, 2025, at 10:43 a.m., resident (R3) stated they would have to yell for staff if they needed assistance. R3 confirmed they did not have a call system such as a button to push to summon staff. On December 4, 2025, at 2:42 p.m., agent (A)-G stated the licensee used to have a call system at their other facilities/locations owned by the same owner. The licensee's Call Light System policy dated	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 460	Continued From page 8 September 1, 2021, indicated all residents would have access to a call light system to request assistance from staff available in their vicinity. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 480	Continued From page 9 clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 480	Continued From page 10 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 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 infection control program that complied with accepted health care, medical and nursing standards for infection control related to hand hygiene and use of PPE (personal	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 510	Continued From page 11 protective equipment) for one of one 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 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 December 3, 2025, at 8:39 a.m., the surveyor observed ULP-A on the lower level of the facility perform hand hygiene in the employee bathroom sink and then don (put on) gloves. ULP-A unlocked the medication cabinet and gathered R5's medications and vital sign equipment from the cabinet. ULP-A then touched the computer with gloved hands to review R5's medication administration record (MAR). ULP-A went upstairs to the main level of the facility and got a glass, filled this with water, and mixed R5's MiraLAX powder in with the water. ULP-A then proceeded to R5's room (room 1) where they checked R5's blood pressure on R5's left arm and then proceeded to give R5 their oral medications. ULP-A went back to the lower level of the facility to document the medication administration on the computer while wearing the same gloves. ULP-A removed the gloves and performed hand hygiene using sanitizer. ULP-A had touched multiple surfaces with the same pair of gloves and did not perform hand hygiene before and after resident cares. On December 3, 2025, at 8:48 a.m., the surveyor	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 510	Continued From page 12 observed ULP-A on the lower level of the facility use hand sanitizer, don gloves, gather medication and supplies from the medication cabinet, compared medications to the MAR on the computer, assisted R4 with medication administration, documented on the computer the medications that were administered, put R4's medication and supplies back in the medication cabinet, then gathered a thermometer. While wearing the same gloves, ULP-A went to the upper level of the facility to R2's room, checked R2's temperature on their forehead, then cleaned the thermometer and placed the thermometer back in the medication cabinet, and then documented the temperature on the computer while wearing the same gloves. ULP-A had touched multiple surfaced while wearing gloves and was not observed to remove gloves or perform hand hygiene between resident cares for R4 and R2. ULP-A's personnel record included competencies for hand washing and use of personal protective equipment (PPE). On December 4, 2025, at 3:34 p.m. clinical nurse supervisor (CNS)-D stated all caregivers were trained on hand hygiene. CNS-D stated the staff must wash their hands before and after care with each resident. CNS-D stated gloves were required for staff when touching any medications, but they should not be touching gloved hands to the computer. The licensee's Hand Washing policy dated September 1, 2021, indicated handwashing would be performed between tasks and procedures. The policy was not consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 510	Continued From page 13 prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. The licensee's Gloves policy dated September 1, 2021, indicated gloves were to be worn whenever there would be direct contact between any employee and contaminated objects. The policy was not 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. The Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings dated October 25, 2002, on page 32, indicated recommendations for handwashing and hand antisepsis to be performed before direct contact with patient (resident); after direct contact with a patient's intact skin; after contact with body fluids or excretions, mucous membranes, nonintact skin or wound dressings; moving from a contaminated-body site to a clean-body site during patient care; after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; after removing gloves, before eating and after using restroom. The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings updated September 2024, on page 129, table 4, indicated recommendations for the application of the use of gloves for touching blood, body fluids, secretions, excretions, contaminated items, for touching mucous membranes, and nonintact skin.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 510	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included annual TB training for two of two unlicensed personnel ((ULP)-A, 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 resident's health or safety, but was not likely to	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 660	Continued From page 15 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated October 1, 2025, identified the facility was at a low risk for TB transmission. ULP-A was hired on June 14, 2019. ULP-A's employee record lacked annual TB training for 2022 and 2024. ULP-F was hired on March 1, 2022. ULP-F's employee record lacked TB training completed at hire and annually for 2023 and 2024. On December 3, 2025, at 11:19 a.m., licensed assisted living director (LALD)-C stated the licensee only provided TB training at hire. On December 4, 2025, at 3:01 p.m., agent (A)-G stated they did not know they needed to provide annual TB training. The licensee's Tuberculosis & Staff Screening policy dated August 1, 2021, indicated employees would be educated regarding TB at the time of hire; and based on the TB Risk Assessment, TB training would be conducted annually in medium risk settings. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently-Asked	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 660	Continued From page 16 Questions (FAQs) website accessed on December 3, 2025, at 11:23 a.m., under Tuberculosis, How Often Should Health Care Personnel Received TB Education, indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. 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.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 680	Continued From page 17 (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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; and failed to post the EPP 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 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 December 2, 2025, at 11:39 a.m., during the facility tour, the surveyor did not observe the licensee's EPP posted prominently. On December 2, 2025, at 11:57 a.m., the surveyor asked unlicensed personnel (ULP)-A for the licensee's EPP. ULP-A stated usually the manager knew where the EPP was placed. On December 2, 2025, at 11:59 a.m., the surveyor asked licensed assisted living director (LALD)-C where the EPP was located. LALD-C stated this should be on the lower level of the facility. The surveyor observed LALD-C going into a file cabinet and at the same time the surveyor observed ULP-A and ULP-E look in a closet	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 680	Continued From page 18 where the licensee's emergency supplies were located. ULP-A and ULP-E had to pull lots of items out of the closet to get the licensee's EPP binder. The licensee's undated EPP lacked evidence of the following required content: - maintain and annual EPP updates (included quarterly missing resident plan review); - policies and procedures for medical documents; - arrangement with other facilities; and - methods for sharing information. On December 2, 2025, at 2:29 p.m., LALD-C stated the licensee did not have a written arrangement with another facility as it has only been a verbal agreement. LALD-C stated they did not realize this needed to be written and signed. The licensee's Emergency Preparedness Plan policy dated September 1, 2021, indicated the EPP would include all the required elements of Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 730	Continued From page 19 (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 730	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's record included a discharge summary for one of two discharged residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's undated Discharged/Expired Client Roster indicated R3 had been discharged on November 3, 2025. R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia and bipolar. R3's Service Plan dated September 5, 2025, indicated R3's services included daily medication administration, daily bathing reminders, daily hygiene/grooming reminders, daily dressing reminders, daily assistance with personal laundry, daily assistance with housekeeping and linen change, and daily food preparation. R3's Observations (progress notes) dated November 2, 2025, at 4:20 a.m., indicated R3 was taken to the hospital following an incident of attacking a staff member.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 730	Continued From page 21 R3's record lacked a discharge summary. On December 4, 2025, at 1:57 p.m., LALD-C confirmed R3 had been discharged from the licensee on November 3, 2025, following an incident. The licensee's undated Resident Records policy indicated the clinical record would include documentation of services provided as identified in the service plan and a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 775	Continued From page 22 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-5-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 780	Continued From page 23 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-5-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 800	Continued From page 24 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-5-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 810	Continued From page 25	0 810			
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. This MN Requirement is not met as evidenced by:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
0 810	Continued From page 26 Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-5-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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	
0 990	Continued From page 27 or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) For a termination pursuant to subdivision 3 or 4, the meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) For a termination pursuant to subdivision 5, the meeting must be scheduled to take place at least five days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (d) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (e) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 990	Continued From page 28 telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a prerequisite to termination of contract meeting with the resident and the resident's representative prior to discharge for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's undated Discharged/Expired Client Roster indicated R3 had been discharged on November 3, 2025. R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia and bipolar. R3's Service Plan dated September 5, 2025, indicated R3's services included daily medication administration, daily bathing reminders, daily hygiene/grooming reminders, daily dressing reminders, daily assistance with personal laundry, daily assistance with housekeeping and linen	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
0 990	Continued From page 29 change, and daily food preparation. R3's Observations (progress notes) dated November 2, 2025, at 4:20 a.m., indicated R3 was taken to the hospital following an incident of attacking a staff member. R3's record lacked documentation of a prerequisite to termination of contract meeting with the resident and the resident's representative at least five days before a notice of termination is issued in an expedited termination. On December 2, 2025, at 12:45 p.m., licensed assisted living director (LALD)-C stated R3 had beaten up a staff member and went to hospital following the incident. LALD-C stated R3 had not been back following the incident and reported R3 was admitted into a psych unit. LALD-C stated the hospital social worker kept asking the licensee if they still had a room for R3, but LALD-C stated they could not allow R3 to come back to the facility. LALD-C stated other residents in the facility are also afraid of R3. LALD-C stated they have had a meeting with R3's county case manager but have not had the official termination meeting due to the violation; and R3 needed a higher level of care. LALD-C stated R3's parents have been understanding as they have suffered with R3 all their lives as well. LALD-C stated the licensee's recommendation to the county case manage was for R3 to go to another facility owned by the same owner of this licensee but R3 would have to be stable first. On December 4, 2025, at 1:57 p.m., LALD-C confirmed R3 had been discharged from the licensee on November 3, 2025. The licensee's Discharge and Transfer of	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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	
0 990	Continued From page 30 Residents policy dated September 1, 2021, indicated prior to issuing a notice of termination, the licensee shall schedule and participate in a pretermination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reasons for the proposed termination and identify/offer reasonable accommodations, modifications, or other alternatives to avoid the termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 990			
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of	01040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01040	Continued From page 31 the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written termination notice at least 15 days before the effective date of an expedited termination to the resident, legal representative, and designated representative; and failed to send a copy of the termination notice to the Office of Ombudsman for Long-Term Care (OOLTC) for one of one resident (R3) who had an expedited termination. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's undated Discharged/Expired Client Roster indicated R3 was discharged on November 3, 2025. R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia and bipolar.	01040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01040	Continued From page 32 R3's Service Plan dated September 5, 2025, indicated R3's services included daily medication administration, daily bathing reminders, daily hygiene/grooming reminders, daily dressing reminders, daily assistance with personal laundry, daily assistance with housekeeping and linen change, and daily food preparation. R3's Observations (progress notes) dated November 2, 2025, at 4:20 a.m., indicated R3 was taken to the hospital following an incident of attacking a staff member. R3's record lacked evidence the licensee issued a written notice of termination and sent a copy of the written termination notice to the Office of Ombudsman for Long-Term Care (OOLTC). On December 4, 2025, at 1:32 p.m., licensed assisted living director (LALD-C) confirmed there was no written notice for R3. LALD-C stated they had called the OOLTC and had left a voicemail but did not provide a copy of the written termination notice to the OOLTC. On December 4, 2025, at 1:57 p.m., LALD-C confirmed R3 had been discharged from the licensee on November 3, 2025. The licensee's Discharge and Transfer of Residents policy dated September 1, 2021, indicated a written notice of an expedited contract termination would be issued to the resident, the resident's legal representative, and the resident's designated representative at least 15 days before the effective date of the termination. The policy did not indicate a copy of the written termination notice would be provided to OOLTC.	01040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01040	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01040			
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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 34 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 November 25, 2025, at 8:39 a.m., in an email, regional ombudsman (RO)-H indicated they had not received any emergency relocation notices from the licensee.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 35 R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia and bipolar. R3's Service Plan dated September 5, 2025, indicated R3's services included daily medication administration, daily bathing reminders, daily hygiene/grooming reminders, daily dressing reminders, daily assistance with personal laundry, daily assistance with housekeeping and linen change, and daily food preparation. R3's Observations (progress notes) dated October 6, 2025, at 8:27 a.m., indicated R3 went to hospital on October 5, 2025, due to having crisis throughout the day. R3's Observations (progress notes) dated October 6, 2025, at 8:41 p.m., indicated R3 had returned to the facility on October 6, 2025, around 4:00 p.m. R3's Observations (progress notes) dated October 30, 2025, at 12:05 p.m., indicated R3 had returned to the facility with emergency medical service (EMS) at approximately 7:00 a.m. The record did not include any notes of R5 being emergently relocated prior to R5's return home with EMS on October 30, 2025. R3's Observations (progress notes) dated November 2, 2025, at 4:20 a.m., indicated R3 was taken to the hospital following an incident of attacking a staff member. R3 had not returned to the facility following this hospitalization. R3's record lacked documentation R3, R3's legal representative, R3's designated representative, and OOLTC had received a written notice with all the required content for an emergency relocation.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 36 On December 4, 2025, at 1:57 p.m., licensed assisted living director (LALD)-C stated in the event of an emergency relocation of sending a resident to the emergency room, the licensee would notify the licensee's nurse and provide the resident/hospital with a copy of the resident's profile with diagnoses and current medications. LALD-C stated, then right away they would get calls from the hospital as they usually requested other information. LALD-C confirmed the licensee had not provided any written notices to a resident or their family in the event of an emergency relocation. LALD-C stated they would just call the resident's family and case manager to inform them of the resident being sent to the emergency room. LALD-C stated they would only notify OOLTC in the event of a discharge from the licensee. The licensee's Discharge and Transfer of Residents policy dated September 1, 2021, indicated the licensee would, as soon as possible, provide written notice in the event of an emergency relocation to the resident, the resident's legal representative, the resident's designated representative, the residents case manager if the resident received home and community-based services, and the Office of Ombudsman for Long-Term Care if the resident did not return to the facility within four days. The policy failed to include the required content for a written emergency relocation notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01320	Continued From page 37	01320			
01320 SS=F	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 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 observation, interview, and record review, the licensee failed to ensure required training were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01320	Continued From page 38 The findings include: On December 3, 2025, at 8:39 a.m., the surveyor observed ULP-A assist residents (R4, R5) with medication administration. ULP-A was hired by the licensee on June 14, 2019. ULP-A's undated Orientation & Training Tracking Form included training for communication and professional boundaries, however the date for the completion of these training topics were left blank on the form. ULP-A's personnel record lacked evidence of completed training for understanding appropriate boundaries between staff and residents and the resident's family. ULP-B was hired by the licensee on February 10, 2024. ULP-B's undated Orientation & Training Tracking Form included training for communication and professional boundaries, however the date for the completion of these training topics were left blank on the form. ULP-B's personnel record lacked evidence of completed training for the following: - 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; and - understanding appropriate boundaries between staff and residents and the resident's family. On December 3, 2025, at 11:44 a.m., licensed	01320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01320	Continued From page 39 assisted living director (LALD)-C stated agent (A)-G would assign all training in Educare (common online training program) for staff. On December 4, 2025, at 3:03 p.m., A-G stated the licensee was not aware of the required training topics as this was an oversight. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy dated September 1, 2021, indicated training for all unlicensed personnel would be kept in each employee's personnel file and the training included the following topics: - 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; and - understanding appropriate boundaries between staff and residents and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01330	Continued From page 40 (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 required training were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 3, 2025, at 8:39 a.m., the surveyor observed ULP-A assist residents (R4, R5) with medication administration. ULP-A was hired by the licensee on June 14, 2019. ULP-A's undated Orientation & Training Tracking Form included training for recognition of physical, emotional, cognitive, and developmental needs of	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01330	Continued From page 41 the client, however the date for the completion of these training topics were left blank on the form. ULP-A's personnel record lacked evidence of completed training for recognition of physical, emotional, cognitive, and developmental needs of the client. ULP-B was hired by the licensee on February 10, 2024. ULP-B's undated Orientation & Training Tracking Form included training for recognition of physical, emotional, cognitive, and developmental needs of the client, however the date for the completion of these training topics were left blank on the form. ULP-B's personnel record lacked evidence of completed training for recognition of physical, emotional, cognitive, and developmental needs of the client. On December 3, 2025, at 11:44 a.m., licensed assisted living director (LALD)-C stated agent (A)-G would assign all training in Educare (common online training program) for staff. On December 4, 2025, at 3:03 p.m., A-G stated the licensee was not aware of the required training topics as this was an oversight. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy dated September 1, 2021, indicated training for all unlicensed personnel would be kept in each employee's personnel file and the training included the following topic for recognition of physical, emotional, cognitive, and developmental needs of the client.	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01330	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01440	Continued From page 43 two 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 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 by the licensee on February 10, 2024. ULP-B's 30-Day Observation Report Form was signed and dated December 9, 2024, by ULP-B. The form was not completed or signed by an RN to indicate a 30-day supervision was completed. ULP-B's personnel record lacked evidence an RN conducted direct supervision of staff performing a delegated task within 30 days of providing services. On December 3, 2025, at 12:46 p.m., licensed assisted living director (LALD)-C stated they usually would put a place holder in the record for the 30-day supervisions, but then they would be completed by the nurse. On December 5, 2025, at 12:43 p.m., clinical nurse supervisor (CNS)-D stated some of their caregivers had personnel files at other facilities owned by the same company and they would check those files for ULP-B's 30-day supervision. CNS-D stated they always complete a 30-day supervision.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01440	Continued From page 44 On December 5, 2025, at 1:04 p.m., licensed assisted living director (LALD)-C stated ULP-B usually worked during the night shift; and ULP-B's duties included cleaning, safety checks and may assist with medication administration. The licensee did not provide a policy regarding supervision of unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
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;	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01500	Continued From page 45 (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 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 at least eight hours of annual training included all the required topics for each 12 months of employment, for two	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01500	Continued From page 46 of two unlicensed personnel ((ULP)-A, 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 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: ULP-A On December 3, 2025, at 8:39 a.m., the surveyor observed ULP-A assist residents (R4, R5) with medication administration. ULP-A was hired by the licensee on June 14, 2019. ULP-A's personnel record lacked evidence of the following required annual training in 2023: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of 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; and - principles of person-centered planning/service delivery. ULP-A's personnel record lacked evidence of the following required annual training in 2024: - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
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. ULP-F ULP-F was hired by the licensee on March 1, 2022. ULP-F's personnel record lacked evidence of the following required annual training in 2023: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - principles of person-centered planning/service delivery. ULP-F's personnel record lacked evidence of the following required annual training in 2024: - infection control techniques; - 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; and - principles of person-centered planning/service delivery. On December 3, 2025, at 11:44 a.m., licensed assisted living director (LALD)-C stated agent (A)-G would assign the annual trainings in Educare (common online training) for the staff to complete.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01500	Continued From page 48 On December 4, 2025, at 2:29 p.m., agent (A)-G stated they usually get emails or newsletters from Care Providers (common consultant company) for any trainings recommended or needed, then they would consult with Educare to assign the courses to staff. A-G stated facility operations manager (FOM)-E had the staff print out their certificates once completed to be filed, then FOM-E would let A-G know the course was completed. A-G confirmed the annual trainings were only assigned according to what Care Providers and Educare recommend every year. On December 4, 2025, at 2:58 p.m., A-G stated the licensee's expectation would be for the staff to complete all the trainings as assigned in Educare. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct home care services must complete at least eight hours of annual training for each 12 months of employment. The policy indicated the annual training topics that are required per MN Statue 144G except assisted living bill of rights and principles of person-centered planning/service delivery. The policy referenced MN Statute 144A (home care) and not MN Statute 144G (assisted living). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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	
01530	Continued From page 49 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the 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;	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01530	Continued From page 50 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees received eight (8) hours of initial dementia care training within the first 160 working hours of employment for two of two unlicensed personnel ((ULP)-A, ULP-B); failed to ensure all employees received two (2) hours of annual dementia care training for direct care employees as required for two of two unlicensed personnel (ULP-A, ULP-F); and failed to ensure all employees received two (2) hours of initial training on topics related to mental illness and de-escalation for direct care staff as required for one of three 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 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: ULP-A On December 3, 2025, at 8:39 a.m., the surveyor observed ULP-A assist residents (R4, R5) with medication administration. ULP-A was hired by the licensee on June 14, 2019. The licensee's Staff Schedule dated December 2,	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01530	Continued From page 51 2025, indicated ULP-A was scheduled December 2, 2025, December 3, 2025, and December 4, 2025, from 8:00 a.m. to 10:00 p.m. for a total of 42 hours. ULP-A's personnel record included seven hours and fifteen minutes (7.25 hours) of dementia care training completed on August 1, 2021, that included the following topics: - problem solving challenging behaviors: Alzheimer's disease and related disorders (3 hours); - communication skills: Alzheimer's disease and related dementias (1 hour); and - assisting clients with Alzheimer's & dementia with activities of daily living (3.25 hours). ULP-A's personnel record lacked evidence of required initial dementia training topics to include an explanation of Alzheimer's disease and other dementias and person-centered planning and service delivery; lacked evidence of two (2) hours of annual dementia care training in 2023 and 2024; and lacked evidence of two hours of initial training on mental illness and de-escalation topics. ULP-B ULP-B was hired by the licensee on February 10, 2024. ULP-B's personnel record lacked evidence of dementia training. ULP-F ULP-F was hired by the licensee on March 1, 2022. ULP-F's personnel record lacked two (2) hours of annual dementia care training in 2023 and 2024.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01530	Continued From page 52 On December 3, 2025, at 11:44 a.m., licensed assisted living director (LALD)-C stated agent (A)-G would assign the annual trainings in Educare (common online training) for the staff to complete. On December 3, 2025, at 1:39 p.m., LALD-C stated the licensee did not have a policy regarding the required mental illness and de-escalation training. LALD-C stated the licensee was aware of the new Statute requirement as of July 2025. On December 4, 2025, at 2:48 p.m., A-G stated they thought the dementia training was only required initially upon hire. LALD-C stated the staff complete the dementia training as soon as they were hired with the nurse using the licensee's dementia training provided on paper documents. LALD-C stated the annual dementia training would then be completed through Educare. LALD-C stated they had personally completed their annual dementia training through Educare. On December 4, 2025, at 2:53 p.m., A-G stated, this year, they added three mental illness courses in the licensee's Educare for staff to complete. On December 4, 2025, at 2:58 p.m., A-G stated the licensee's expectation would be for the staff to complete all the trainings as assigned in Educare. On December 4, 2025, at 2:56 p.m., licensed assisted living director (LALD)-C stated ULP-B had not been an employee for a year yet. LALD-C confirmed ULP-B had worked more than 160 hours. LALD-C stated ULP-B should have	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01530	Continued From page 53 completed the dementia training. The licensee's Dementia Training policy dated September 1, 2021, indicated direct care employees would complete eight (8) hours of initial dementia care training prior to being able to provide direct care unless there was another employee onsite who had completed the training for the following topics: - An explanation of Alzheimer's Disease and other dementias; - Assistance with activities of daily living (ADL's); - Problem solving with challenging behaviors; - Communication skills; and - Person-centered planning and service delivery. Also, the policy indicated all staff would complete two (2) hours of additional dementia training for each twelve (12) months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=F	144G.70 Subd. 2 (a-b) 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	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01610	Continued From page 54 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. 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 an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for two of two residents (R2, R3) receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on February 13, 2023, with a diagnosis of schizophrenia (serious mental health condition that affects how people think, feel and behave). R2's Service Plan dated February 21, 2023, indicated R2 received services for medication administration. R2's Assisted Living Contract for Housing and	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01610	Continued From page 55 Services was signed on February 13, 2023. R2's assessment dated February 16, 2023, indicated the initial assessment was completed three days after R2 had executed a contract with the facility and three days after the resident moved into the facility. R3 R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia, bipolar, attention deficit hyperactivity disorder (ADHD) (symptoms that can interfere with daily activities), and anxiety. R3's Service Plan dated September 5, 2025, indicated R3 received services for medication administration. R3's Assisted Living Contract for Housing and Services was signed on August 22, 2025. R3's assessment dated August 23, 2025, indicated the initial assessment was completed one day after R3 had executed a contract with the facility and one day after the resident moved into the facility. On December 5, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)- D stated they were told they had days to complete an assessment. The licensee's Assessment Schedule policy dated September 1, 2021, indicated initial individualized assessments would be completed within five days after the initiation of home care services. The policy failed to indicate a registered nurse (RN) must complete an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01610	Continued From page 56 the resident moved into the facility. The policy referenced MN Statute 144A (home care) and not MN Statute 144G (assisted living). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 57 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 the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2 was admitted to the licensee on February 13, 2023, with diagnosis of schizophrenia (serious mental health condition that affects how people think, feel and behave). R2's Service Plan dated February 21, 2023, indicated R2 received services as followed: -medication administration (no frequency) by unlicensed personnel (ULP); -bathing assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services); -hygiene/grooming assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services); -dressing assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services);	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 58 and -food preparation (no frequency) by ULP. The service plan identified the resident was responsible for the bill and the fees for services would be attached to the service plan. The service plan lacked a description of fees for the services and did not have an attachment of the fees for services. Also, the service plan lacked the frequency of services according to the resident's current assessment and resident preferences; and lacked the identification of staff or categories of staff who would provide each service. R3 R3 was admitted to the licensee on September 5, 2025, with a diagnoses of schizophrenia, bipolar, attention deficit hyperactivity disorder (ADHD) (symptoms that can interfere with daily activities), and anxiety. R3's Service Plan dated February 21, 2023, indicated R2 received services as followed: -medication administration (no frequency) by ULP; -bathing assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services); -hygiene/grooming assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services); -dressing assistance (no frequency) for self-reminders (no identification of staff or categories of staff who will provide the services); and -food preparation (no frequency) by ULP. The service plan identified the resident was responsible for the bill and the fees for services would be attached to the service plan. The service plan lacked a description of fees for the	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 59 services and did not have an attachment of the fees for services. Also, the service plan lacked the frequency of services according to the resident's current assessment and resident preferences; and lacked the identification of staff or categories of staff who would provide each service. On December 4, 2025, at 2:23 p.m., licensed assisted living director (LALD)-C stated the licensee did not have any attachments that described the fees for services. LALD-C stated the licensee could improve on that. On December 5, 2025, at 1:04 p.m., LALD-C they were aware of the required content for a service plan however it was an oversight that they were not included. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must include the following: - a description of the assisted living services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the client's current review or assessment and client preferences; - the identification of the type staff (registered nurse (RN)/licensed practical nurse (LPN), therapists, unlicensed personnel, etc.) that will provide the services; and - the frequency of sessions of supervision of staff and type of personnel who will supervise staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01710	Continued From page 60	01710			
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 annual medication re-assessments for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R2 was admitted to the licensee on February 13, 2023, with diagnosis of schizophrenia (serious mental health condition that affects how people think, feel and behave). R2's Service Plan dated February 21, 2023,	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
01710	Continued From page 61 indicated R2 received services for medication administration. R2's Medication/ Treatment/ Therapy Management Plan dated February 16, 2023, indicated R2's medication management services included medication administration by unlicensed personnel. R2's Medication Assessment dated February 16, 2023, indicated R2 was deemed unable to safely administer medications. R2's records lacked evidence of an annual medication re-assessment. On December 5, 2025, at 12:16 p.m., clinical nurse supervisor (CNS)-D stated they would only complete a medication assessment if there was a change in condition; and if a resident were to be discharged from the hospital, then they would review the medications but would not complete a medication assessment. CNS-D stated R2 has not had any hospitalizations or changes in condition, so their medication assessment was only completed at the initial start of care. CNS-D stated the licensee's uniform assessment did not include a medication assessment, but they thought if the assessment indicated no change that it would be acceptable. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated an RN would conduct an assessment to determine what medication management services would be provided and how the services would be provided. The policy indicated the licensee would monitor and reassess the resident's medication management services as needed when the	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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
01710	Continued From page 62 resident presented with symptoms or other issues that may be medication-related and, at minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710			
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 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 interview and record review, the licensee failed to document the signature and title of staff who completed medication administration; and failed to document the reason why medication administration was not completed as prescribed and any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for two of two residents (R2, R3).	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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 63 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: R2 R2 was admitted to the licensee on February 13, 2023, with a diagnosis of schizophrenia (serious mental health condition that affects how people think, feel and behave). R2's Service Plan dated February 21, 2023, indicated R2 received services for medication administration. R2's Medication Assessment dated February 16, 2023, indicated R2 was deemed unable to safely administer medications. R2's MAR dated November 2025, lacked signatures and the titles of staff who had administered the medications. R2's MAR indicated R2 was to receive Lybalvi 5-10 milligrams (mg) daily. R2's MAR lacked documentation of administration of Lybalvi on November 20, 2025, and November 27, 2025. R3 R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia, bipolar, attention deficit hyperactivity disorder (ADHD) (symptoms that can interfere with daily activities), and anxiety.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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 64 R3's Service Plan dated September 5, 2025, indicated R3 received services for medication administration. R3's assessment dated October 10, 2025, and November 1, 2025, indicated medication administration was completed by unlicensed personnel. R3's MAR dated October 2025, lacked signatures and the titles of staff who had administered the medications. R3's MAR indicated R3 was to receive the following scheduled medications but had lacked documentation of the administration as followed: - atomoxetine 25 mg every morning at 9:00 a.m. on October 3, 2025, and October 8, 2025; - Jardiance 10 mg daily on October 3, 2025, and October 8, 2025; and - memantine 5 mg twice daily at 9:00 a.m. on October 3, 2025, and October 8, 2025; and - memantine 5mg twice daily at 9:00 p.m. on October 2, 2025, October 22, 2025, October 23, 2025, October 29, 2025, and October 30, 2025. On December 5, 2025, at 12:37 p.m., clinical nurse supervisor (CNS)-D stated the licensee's MAR was not designed to include the staff signatures and their titles. CNS-D stated staff should always document why a medication is not administered as ordered; and it was not acceptable to have omitted entries on the MAR. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated September 1, 2021, indicated a signature and title of the authorized person who provided the medication administration should be included in the resident's medication record. The policy	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305			
(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 65 indicated if medication administration were not completed as prescribed, documentation must include the reason why it was not administered and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required residents to sign and follow house rules for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
02290	Continued From page 66 On December 2, 2025, at 11:39 a.m., during a tour of the facility, the surveyor observed "House Rules" posted in a common living room area. R2 R2 was admitted to the licensee on February 13, 2023, with a diagnosis of schizophrenia (serious mental health condition that affects how people think, feel and behave). R2's Service Plan dated February 21, 2023, indicated R2 received services for medication administration. R2's undated House Rules and Regulation was signed by R2. The house rules indicated the following: - no alcohol, drugs or drug paraphernalia while a resident; - subject to random drug and alcohol tests; - perform a room search at any time (included personal items and vehicles); - threats or acts of violence would result in immediate discharge; - no firearms, hunting knives or other weapons permitted; - smoking permitted until 11:00 p.m. unless otherwise approved by staff; - house curfew at 10:00 p.m. every night; - headphones must be used after 9:00 p.m.; - restricted content of pictures on the walls of the resident rooms; - the director had the final decision as to whether a resident followed the rules and remained at the facility; and - rules were subject to change without notice. R3 The licensee's Discharged/Expired Client Roster provided to the surveyor on December 2, 2025,	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
02290	Continued From page 67 indicated R3 had been discharged on November 3, 2025. R3 was admitted to the licensee on August 22, 2025, with diagnoses of schizophrenia, bipolar, attention deficit hyperactivity disorder (ADHD) (symptoms that can interfere with daily activities), and anxiety. R3's Service Plan dated September 5, 2025, indicated R3 received services for medication administration. R3's House Rules was signed by R3 on February 1, 2024. The house rules indicated the following: - no alcohol, drugs or drug paraphernalia while a resident; - subject to random drug and alcohol tests; - perform a room search at any time (included personal items and vehicles); - threats or acts of violence would result in immediate discharge; - no firearms, hunting knives or other weapons permitted; - smoking permitted until 11:00 p.m. unless otherwise approved by staff; - house curfew at 10:00 p.m. every night; - headphones must be used after 9:00 p.m.; - restricted content of pictures on the walls of the resident rooms; - the director had the final decision as to whether a resident followed the rules and remained at the facility; and - rules were subject to change without notice. On December 2, 2025, at 12:11 p.m., licensed assisted living director (LALD)-C acknowledged the licensee's house rules for residents to follow. On December 5, 2025, at 1:31 p.m., LALD-C	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA WELLNESS CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 724 ROBINWOOD LANE HOPKINS, MN 55305		
(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
02290	Continued From page 68 confirmed all residents had to sign house rules upon admission. LALD-C stated they also sent the house rules to the resident's family as well. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02290			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Minnesota Wellness Center Llc
724 Robinwood Lane
Hopkins, MN 55305
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34346

Risk:
License:
Expires on:
CFPM: Ubar Shirwa
CFPM #: FM108613; Exp: 11/24/2027

Inspection Info

Report Number: F1039251216
Inspection Type: Full - Single
Date: 12/2/2025 Time: 10:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B Priority Level: Priority 3 CFP#: 41

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: WET WIPING CLOTH HELD ON OVEN HANDLE. STORE IN SANITIZER SOLUTION OR USE ALTERNATE MEANS OF WIPING, SUCH AS DISPOSABLE PAPER TOWEL AND SANITIZER SPRAY. WIPING CLOTH REMOVED FROM KITCHEN.

Comply By: 12/2/2025 Originally Issued On: 12/2/2025

New Order: 3-500C Microbial Control: date marking

3-501.17B Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date. COMMENT: OPEN PACKAGES OF MILK, COTTAGE CHEESE LACK DATE MARKS. COMPLY WITH ABOVE RULE FOR THESE FOODS.

Comply By: 12/2/2025 Originally Issued On: 12/2/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: NO MAX HOLD WATERPROOF THERMOMETER OR COLOR CHANGE THERMO STRIPS ARE ON-HAND AT ESTABLISHMENT. COMPLY WITH ABOVE RULE AND USE DEVICE TO MONITOR DISH MACHINE MAX TEMPERATURE.

Comply By: 12/12/2025 Originally Issued On: 12/2/2025

Food & Beverage General Comment

MILK - COLD HOLD, REFRIGERATOR - 38 DEGREES F
FREEZERS -FROZEN (ADDITIONAL FREEZER PRESENT IN BASEMENT)

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Rhawnie Quinehan.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. By thermo test strip results emailed by person-in-charge, the dishwashing machine rinse temperature at utensil surface exceeds 160 degrees f

Discussed the following with the person-in-charge: food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on this report.

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

I acknowledge receipt of the Metro District Office inspection report number F1039251216 from 12/2/2025



Al Abrar
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34346016-0	Date: 12/15/2025
Facility Name: MINNESOTA WELLNESS CENTER LLC	
Facility Address: 724 Robinwood Ln Hopkins, Minnesota 55305)	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Licensee’s evacuation drill log indicated drills were completed for second shift on November 26, 2024 and June 2, 2025. Licensed assisted living director (LALD)-C stated those were the only evacuation drills performed in the last 12 months.
2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: No staff policy was provided by LALD-C when a policy was requested. LALD-C stated the facility does not have a policy in place at this time.
3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: No resident policy was provided by LALD-C when a policy was requested. LALD-C stated the facility does not have a policy in place at this time.
4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-C lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. LALD-C stated they do training when they do fire drills but do not document the trainings.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. LALD-C stated they do training when they do fire drills but do not document the trainings.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: Bedroom 3 had a number of holes in the walls and doors, and an outlet was loose and not secured to the wall.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: Licensed assisted living director (LALD)-C tested the smoke alarms for operability and interconnection. Two separate smoke alarm systems were present but not interconnected..

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: The dryer vent was disconnected to the elbow above the ceiling tiles. Lint was collecting in the facility and not exhausting to the exterior.

2. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: An approved cigarette receptacle was provided for the residents of the facility, but cigarette butts were observed on the ground around the receptacle.

4. Materials and firestop systems used to protect membrane and through penetrations in fire-resistance-rated construction and construction installed to resist the passage of smoke shall be maintained. The materials and firestop systems shall be securely attached to or bonded to the construction being penetrated with no openings visible through or into the cavity of the construction. [Minn. Stat. 144G.45 subd. 2; MSFC 703.1]

Comments: The fire separation between the house and the garage had a through penetration from an electrical wire. This penetration was not sealed to prevent the passage of fire