



HEALTH REGULATION DIVISION
NOTICE AND ORDER OF IMMEDIATE TEMPORARY SUSPENSION
AND NOTICE OF REVOCATION

In the Matter of Bright Path Homes
6800 Quail Avenue North
Brooklyn Center, MN 55429

MDH HFID # 37090

IT IS ORDERED that the Minnesota Department of Health ("Department" or "MDH") is immediately temporarily suspending the assisted living facility license for Bright Path Homes ("Bright Path"), license number 421147, for ninety (90) days, under the provisions of Minn. Statutes § 144G.20, Subd. 3.

IT IS FURTHER ORDERED that the Department revokes the assisted living facility license for Bright Path, license number 421147, under the provisions of Minn. Statutes § 144G.20, Subd. 1.

Facts and Law:

1. Minn. Stat. § 144G authorizes the Department to regulate assisted living facilities in Minnesota. This authority includes issuing assisted living facility licenses, conducting surveys to determine compliance with the assisted living laws, and conducting complaint investigations of alleged violations of the assisted living facility laws. The Commissioner of Health is authorized by Minn. Stat. § 144G.20, Subd. 3 to immediately temporarily suspend an assisted living facility license for not more than ninety (90) days if Level 5 violations are cited at the facility or if violations are found which "pose an imminent risk of harm to the health or safety of residents." The Commissioner of Health is also authorized to revoke an assisted living facility license pursuant to Minn. Stat. § 144G.20, Subd. 1 if certain conditions occur.

2. On August 1, 2021, MDH issued an assisted living facility license to Bright Path, which was renewed most recently on May 1, 2025.

3. On September 16 to 18, 2024, MDH conducted a survey under Minn. Stat. 144G.30 Subd. 2. During the survey, MDH identified a violation of Minn. Stat. § 144G.45, Subd. 2(g), which requires correction of any element deemed a distinct hazard to life. MDH issued a correction order on October 23, 2024, indicating the licensee (Bright Path) failed to provide resident bedrooms with the window opening size to meet the minimum state standard for egress. In addition, the correction order noted cigarette

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butts were observed on the ground around the facility, rather than disposed of in a safe receptacle.

4. On December 2, 2024, MDH conducted a follow-up survey as required by Minn. Stat.

144G.30, Subd. 7. During this survey, the licensee indicated the non-compliant egress windows had not yet been replaced. The licensee indicated they were conducting a fire watch as a corrective measure; however, the fire watch logs were not consistently completed. MDH re-issued a correction order for violation of Minn. Stat. § 144G.45, Subd. 2(g).

5. On February 24, 2025, MDH conducted a follow-up survey under Minn. Stat. 144G.30, Subd. 6. The follow-up survey identified the following new violations, which were both issued in correction orders sent March 28, 2025:

a. Minn. Stat. § 144G.45, Subd. 2(a), each assisted living must comply with the State Fire Code. During the follow-up survey, MDH staff observed two residents' rooms which contained evidence of unsafe disposal of smoking materials, including burns marks and melting on a windowsill where it appeared cigarettes were extinguished, ash on a dresser, and used cigarettes disposed into a plastic cup. The State Fire Code requires disposal in non-combustible containers.

b. Minn. Stat. § 144G.45, Subd. 2(a)(4), each assisted living facility must keep the physical environment in a continuous state of good repair. During the follow-up survey, MDH staff observed a large hole in the door to a closet in the first-floor hallway. Facility staff members stated a resident punched a hole in the door.

6. On May 19, 2025, MDH conducted a follow-up survey under Minn. Stat. 144G.30, Subd. 6. The follow-up survey identified the following violations, which were issued in correction orders sent July 11, 2025:

a. Minn. Stat. § 144G.30, Subd. 5, an assisted facility must document actions taken to comply with a correction order. The licensee reported actions taken to address unsafe smoking in the facility but did not provide documentation of those actions.

b. Minn. Stat. § 144G.45, Subd. 2(a), each assisted living facility must comply with the State Fire Code. During the follow-up survey, MDH staff again observed evidence of unsafe disposal of smoking materials, including continued burn marks and melting on the windowsill of a resident's room, and new burn marks on the window frame.

7. On November 13, 2025, MDH conducted a follow-up survey as required by Minn. Stat. 144G.30, Subd. 7. The follow-up survey identified the following violations:

a. Minn. Stat. § 144G.30, Subd. 5, an assisted living facility must document actions taken to comply with a correction order. The licensee did not provide documentation of actions taken to address the previous correction orders.

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b. Minn. Stat. § 144G.45, Subd. 2(a), each assisted living must comply with the State Fire Code. During the follow-up survey, MDH staff observed evidence of unsafe disposal of smoking materials, including additional burn marks on furniture and bedding. Facility staff members reported a resident continued to smoke inside.

[These violations are elaborated in the attached state form, enclosure 1.]

8. Also on November 13, 2025, investigators of the Office of Health Facility Complaints ("OHFC") entered Bright Path to conduct complaint investigations under Minn. Stat. § 144G.30, concurrently with maltreatment investigations under Minn. Stat. § 626.557.

During the investigation, MDH identified the following violations:

a. Minn. Stat. § 144G.45, Subd. 2(a)(1), each assisted living facility must provide

smoke alarms in each room used for sleeping purposes and outside each separate sleeping area, which are interconnected. The licensee failed to provide smoke alarms that were interconnected. In addition, the smoke alarm in the first-floor hallway did not operate when tested.

b. Minn. Stat. § 144G.45, Subds. 2(a)(2) and (3), each assisted living facility must install and maintain portable fire extinguishers in accordance with the State Fire Code. The licensee failed to maintain their portable fire extinguishers, as indicated by service tags which showed it had been over a year since the fire extinguishers were serviced; the State Fire Code requires them to be serviced or replaced annually.

c. Minn. Stat. § 144G.45, Subd. 2(a)(4), each assisted living facility must keep the physical environment in a continuous state of good repair. During the investigation, MDH staff observed multiple holes in the walls, food remnants and food packaging on the floor and furniture, fecal matter on the floor, a handle missing on an egress window, light fixtures missing protective globe coverings, and other damage. In addition, one room smelled strongly of urine and feces. Multiple rooms had staining on the walls.

d. Minn. Stat. § 144G.45, Subds. 2(b) through (f), each assisted living facility must develop and maintain fire safety and evacuation plans. The licensee did not provide an evacuation plan, or documentation of training and evacuation drills, when requested by MDH staff.

e. Minn. Stat. § 144G.50, Subd. 1, an assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract. An individual was living in the facility who had not signed an assisted living contract.

[These violations are elaborated in the attached state form, enclosure 2.]

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9. Based on these findings, MDH determined the violations occurred and pose an imminent risk of harm to the health and safety of residents.

a. The licensee was aware of residents who were smoking in the facility and extinguishing their smoking materials in a way which caused burn marks. The facility failed to adequately address this. The continued finding of these burn marks indicates an imminent risk of a fire occurring in the facility.

b. The licensee failed to comply with multiple fire safety requirements, including functioning smoke alarms, interconnected smoke alarms, having an evacuation plan, and conducting evacuation drills. The violations create a likelihood of serious injury or death if a fire occurred, because staff and residents would not be properly alerted and would not be prepared to evacuate.

c. The licensee failed to provide a physical environment which supported the health, safety, and wellbeing of residents. The extent of damage and uncleanliness of the facility poses multiple risks to the residents, including some which would be an imminent risk of harm to health and safety.

10. The foregoing violations constitute grounds to revoke a license under Minn. Stat. § 144G.20, Subd. 1(a)(1), (3), and (13).

[Temporary Suspension and Requirement for Transition Plan](#)

This letter notifies you that MDH is immediately temporarily suspending the assisted living facility license number 421147 for ninety (90) days, thereby prohibiting you from operating the assisted living facility.

Minn. Stat. § 144G.20, Subd. 12(a) states:

“Within five business days after proceedings are initiated by the commissioner to revoke or suspend a facility's license, or a decision by the commissioner not to renew a living facility's license, the controlling individual of the facility or a designee must provide to the commissioner,

the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names of residents and the names and addresses of the residents'

designated representatives and legal representatives, and family or other contacts listed in the

assisted living contract.”

Minn. Stat. § 144G.20, Subd. 15 states:

“(a) The process of suspending, revoking, or refusing to renew a license must include a plan for transferring affected residents' cares to other providers by the facility. The commissioner

shall monitor the transfer plan. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension, the licensee shall provide the commissioner, the lead

agencies as defined in section 256B.0911, county adult protection and case managers, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities with the following information:

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(1) a list of all residents, including full names and all contact information on file;

(2) a list of the resident's legal representatives and designated representatives and family or other contacts listed in the assisted living contract, including full names and all contact information on file;

(3) the location or current residence of each resident;

(4) the payer sources for each resident, including payer source identification numbers; and

(5) for each resident, a copy of the resident's service plan and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The licensee shall cooperate with the commissioner and the lead agencies, county adult protection and case managers, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities during the process of transferring care of residents to qualified providers. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension action, the facility must notify and disclose to each of the residents, or the resident's legal and designated representatives or emergency contact persons, that the commissioner is taking action against the facility's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility does not comply with the disclosure requirements in this section, the

commissioner shall notify the residents, legal and designated representatives, or emergency contact persons about the actions being taken. Lead agencies, county adult protection and case managers, and the Office of Ombudsman for Long-Term Care may also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.”

The temporary suspension is in effect immediately; however, you are required to ensure residents receive necessary care until they are safely transferred to other facilities. Once all residents are transferred, you must not provide assisted living services to anyone as long as the

temporary suspension is in effect. Pursuant to Minn. Stat. § 144G.10, Subd. 4, operating an assisted living facility without a license is a misdemeanor.

[Expedited Hearing Regarding Immediate Temporary Suspension](#)

Pursuant to Minn. Stat. § 144G.20, Subd. 17(a):

“Within five business days of receipt of the licensee's timely appeal of a temporary suspension or issuance of a conditional license, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 30 calendar days of the request for assignment, unless an extension is requested by either party and

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granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension or issuance of a conditional license should remain in effect and whether there is sufficient evidence to conclude that the licensee's actions or failure to comply with applicable laws are Level 3 or Level 4 violations as defined in section 144G.31, or that there were violations that posed an imminent risk of harm to the resident's health and safety.”

You may appeal the temporary suspension. Pursuant to Minn. Stat. 144G.20, Subd. 3(c), the appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to MDH within five calendar days after you receive this order.

The appeal can be sent to the following address:

Reconsideration Unit, Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

625 Robert Street North

Saint Paul, MN 55155

If an appeal is made by personal service, it must be received by MDH within five calendar days after you receive this order and be served to:

Minnesota Department of Health

Attn: General Counsel's Office

Freeman Office Building

625 Robert Street North

Saint Paul, MN 55155

If a timely appeal is received, MDH is required by Minn. Stat. § 144G.20, Subd. 17(a) to

request assignment of an Administrative Law Judge within five business days of receipt of the appeal. A hearing must be conducting within 30 calendar days of the request for assignment of an Administrative Law Judge, and the Commissioner must issue notice of the hearing at least ten business days before the hearing. The scope of the hearing will be limited to whether the temporary suspension should remain in effect and whether there is sufficient evidence to conclude there were violations that posed an imminent risk of harm to the resident's health and safety.

Under Minn. Stat. 144G.20, Subd. 17(b), the Administrative Law Judge will issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties will then have ten calendar days to submit exceptions to the Administrative Law Judge's report. The record must close at the end of the ten-day period for submission of

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exceptions. The Commissioner's final order will be issued within ten business days from the close of the record. If the final order affirms an immediate suspension, the licensee is prohibited from operation pending a final order on any appeal of the revocation issued below.

Under Minn. Stat. 144G.20, Subd. 17(b), if an appeal of a temporary immediate suspension is withdrawn or dismissed, the Commissioner will issue a final order affirming the temporary immediate suspension within ten calendar days of MDH's receipt of that dismissal or withdrawal.

[Revocation and Appeal of the Revocation](#)

This letter also notifies you that MDH is revoking the assisted living facility license number 421147.

1. Relationship to the Immediate Temporary Suspension: Pursuant to Minn. Stat. § 144G.20, Subd. 17(c), if the final order from the expedited hearing process (described above) affirms the immediate temporary suspension, and a final sanction is issued under Minn. Stat. § 144G.20, subds. 1 and 2, "the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14." Therefore, if the immediate temporary suspension issued above is upheld by the Commissioner of Health, you are prohibited from providing assisted living services unless and until the facility successfully appeals this Notice of Revocation and the Commissioner issues a final order reversing this Notice of Revocation.

2. Impact on issuance of other licenses: Minn. Stat. § 144G.20, Subd. 5 (a) states that if a Minnesota assisted living facility license is "revoked because of noncompliance with applicable laws or rules," then the owner and managerial officials of that assisted living facility "shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment."

Further, Minn. Stat. § 144G.20, Subd. 5 (c) indicates "the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose license

in this state, or any other state was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.”

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3. You may appeal this decision.

a. Minn. Stat. § 144G.20, Subd. 13 states you are entitled to a contested case hearing under Minn. Stat. §§ 14.57 to 14.69.

b. Minn. Stat. § 144G.20, Subd. 18 states to appeal “an action against a license under this section, a licensee must request a hearing no later than 15 business days after the licensee receives notice of the action.”

c. You may appeal the revocation, whether or not you also appeal the temporary suspension.

The appeal must be made in writing by mail or delivered to MDH, per Minn. Stat. § 144G.20, Subd. 14, and must contain “a brief and plain statement describing every matter or issue contested” and “a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor.” The appeal can be sent to the following address:

Reconsideration Unit, Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

625 Robert Street North

Saint Paul, MN 55155

4. Minn. Stat. § 144G.20, Subd. 16 states “Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee.”

5. If you do not request a hearing within 15 business days of your receipt of this notice, or if an appeal of the revocation is withdrawn or dismissed, this Notice will become the Commissioner's order of revocation.

[Issuance of Survey Results / No Limited Authority:](#)

MDH will continue to conduct any surveys or investigations already initiated and may issue correction orders to Bright Path as well as maltreatment determinations under Minn. Stat. § 626.557. Based on the results of those findings, or on the results of any additional complaint

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investigations which may be initiated, or on the results of any other inspection conducted by MDH or another agency with appropriate jurisdiction, MDH may employ any of the enforcement

tools listed in Minn. Stat. § 144G.20. This Order does not in any way or manner limit or affect



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the
authority of MDH to proceed against the facility or any employee of the facility, based on any
act,
conduct, or admission that justifies that action, whether it occurred before or after the date of
this Order.

MARIA KING
DIVISION DIRECTOR
MINNESOTA DEPARTMENT OF HEALTH
HEALTH REGULATION DIVISION

Maria King, RN

Enclosures:

Attachment 1 – State Form, correction orders for SL37090015-4

Attachment 2 – State Form, correction orders for complaint investigation,
HL370902240C



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 11, 2025

Licensee

Bright Path Homes LLC

6800 Quail Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL37090015

Dear Licensee:

On May 20, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 18, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 18, 2024, found not corrected at the time of the May 20, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on May 20, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 20, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$3,000.00

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", is written over a light gray rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/20/2025
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37090015-3 On May 19, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a follow-up survey completed on February 24, 2025. At the time of the survey, there were 4 residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/20/2025
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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	
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, and interview the licensee failed provide documentation with actions taken to comply with correction orders from a follow-up survey completed on February 24, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/20/2025
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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	
0 340	Continued From page 2 serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: SMOKING OBSERVATION: During a follow-up survey that was conducted February 24, 2025, the licensee was cited using the 0775-tag identification number for failing to ensure smoking was taking place in the designated outdoor area, being extinguished in a safe manner, and disposed of in appropriate ash trays. On May 19, 2025, survey staff confirmed the deficient condition remained. There were more burn marks in resident room A on the windowsill and new burn marks on the bottom center of the window frame. INTERVIEW: The surveyor conducted an interview on May 19, 2025, with house manager (HM)-C. HM-C stated resident has not smoked inside of the room since the follow-up survey. HM-C stated that they remind all residents every morning that smoking should take place outside. HM-C stated that residents had a meeting with licensed assisted living director (LALD)-A sometime after the follow-up survey conducted on February 24, 2025, and LALD-A told all residents that smoking should take place outside. HM-C lacked documentation of LALD-A meeting with residents or topics discussed during the meeting. HM-C stated that all residents had signed the no smoking policy at time of placement but have not	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/20/2025
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
0 340	Continued From page 3 re-signed the policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340	Not reviewed during this survey.		
{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:	{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	{0 480}			

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{0 480}	Continued From page 4 Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;	{0 480}			

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{0 480}	Continued From page 5 (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.		
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly	{0 650}	Not reviewed during this survey.		

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{0 650}	Continued From page 6 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	{0 660}	Not reviewed during this survey.		

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{0 660}	Continued From page 7 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:	{0 660}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	{0 680}			

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{0 680}	Continued From page 8 requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 19, 2025, at 11:30 a.m. the surveyor conducted a follow-up survey with house manager (HM)-C on orders issued pursuant to a follow-up survey completed on February 24, 2025. The following was observed. In resident room A cigarettes were being	{0 775}			

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{0 775}	Continued From page 9 extinguished on the windowsill resulting in several burn marks as well as melting of the windowsill. There were also burn marks on the bottom center of the window frame itself. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material.	{0 775}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}	Not reviewed during this survey.		

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{0 970}	Continued From page 10 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.		
{01060} SS=D	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	{01060}			

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{01060}	Continued From page 11 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must	{01460}			

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{01460}	Continued From page 12 document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}	Not reviewed during this survey.		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning	{01470}			

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{01470}	Continued From page 13 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01470}			

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{01470}	Continued From page 14	{01470}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	{01500}			

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{01500}	Continued From page 15 (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:	{01500}	Not reviewed during this survey.		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental	{01530}			

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{01530}	Continued From page 16 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; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01560} SS=F	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De-	{01560}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/20/2025
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
{01560}	Continued From page 17 (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. This MN Requirement is not met as evidenced by:	{01560}	Not reviewed during this survey.		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 18 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}			

Minnesota Department of Health
STATE FORM 6899 CX1114 If continuation sheet 20 of 20



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 28, 2025

Licensee

Bright Path Homes LLC

6800 Quail Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL37090015

Dear Licensee:

On February 24, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2024, and the follow-up survey completed on December 2, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 2, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 2, 2024, found not corrected at the time of the February 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on February 24, 2025, we identified the following violation(s):

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in

- §144G.20 for widespread violations;
Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

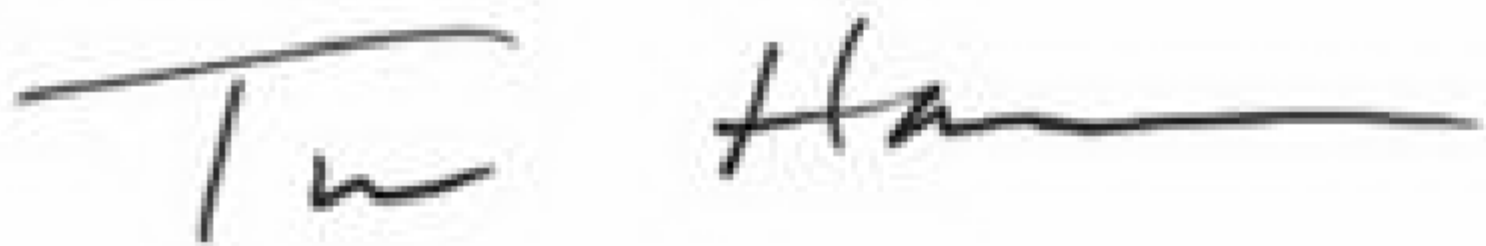
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,



Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#37090015-2 On February 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 18, 2024. At the time of the survey, there were 4 residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were new orders issued.	{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.		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 460}	Continued From page 1 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: Not reviewed during this survey.	{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	{0 480}			

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

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{0 480}	Continued From page 3	{0 480}			
{0 630} SS=D	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 630}			
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	{0 650}			

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{0 650}	Continued From page 4 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			

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{0 660}	Continued From page 5 Not reviewed during this survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775			

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0 775	Continued From page 6 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and 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 potential to affect a large portion or all of the residents). The findings include: On February 24, 2025, at 10:35 a.m. the surveyor conducted a follow-up with house manager (HM)-C for orders issued pursuant to a survey completed on September 18, 2024, and orders re-issued pursuant to a follow up conducted on December 2, 2024. In resident room A cigarettes were being extinguished on the windowsill resulting in several burn marks as well as melting of the windowsill. There was also cigarette ash on top of the dresser next to the egress window. HM-C stated that they have advised resident that smoking is not allowed inside but could not elaborate on how they are enforcing the no smoking inside the facility.	0 775			

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0 775	Continued From page 7 In resident room B there were cigarettes that were being discarded into a plastic cup on the floor of the room. HM-C stated that they have advised resident that smoking is not allowed inside but could not elaborate on how they are enforcing the no smoking inside the facility. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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	{0 800}			

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{0 800}	Continued From page 8 residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 24, 2025, at 10:35 a.m. the surveyor conducted a follow-up with house manager (HM) - C for orders issued pursuant to a survey completed on September 18, 2024, and orders re-issued pursuant to a follow up conducted on December 2, 2024. The door to the "staff closet" in the first-floor common hallway had a hole in it that was approximately 12 inches high and 8 inches wide. HM-C stated that one of the residents had punched a hole in the door. The siding on the outside of resident room A was missing from where the new window was installed. HM-C stated that the siding is going to be replaced in the spring. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 800}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	{0 970}			

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{0 970}	Continued From page 9 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}			
{01060} SS=D	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	{01060}			

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NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
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{01060}	Continued From page 10 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01060}			
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted	{01460}			

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{01460}	Continued From page 11 living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01460}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	{01470}			

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{01470}	Continued From page 12 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	{01470}			

NAME OF PROVIDER OR SUPPLIERSTREET ADDRESS, CITY, STATE, ZIP CODE

BRIGHT PATH HOMES LLC

**6800 QUAIL AVENUE NORTH
BROOKLYN CENTER, MN 55429**

 $\{01470\}$

Continued From page 13

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:
Not reviewed during this survey.

 $\{01470\}$ $\{01500\}$

{01500}
SS=E

144G.63 Subd. 5 Required annual training

(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:

- (1) training on reporting of maltreatment of vulnerable adults under section 626.557;
- (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
- (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with

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{01500}	Continued From page 14 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: Not reviewed during this survey.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	{01530}			

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{01530}	Continued From page 15 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}			
{01560} SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and	{01560}			

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{01560}	Continued From page 16 other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01560}			
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	{01730}			

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{01730}	Continued From page 17 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	{01760}			

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{01760}	Continued From page 18 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: Not reviewed during this survey.	{01760}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 31, 2025

Licensee

Bright Path Homes LLC

6800 Quail Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL37090015

Dear Licensee:

On December 2, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 18, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 18, 2024, found not corrected at the time of the December 2, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on December 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up survey completed on December 2, 2024, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

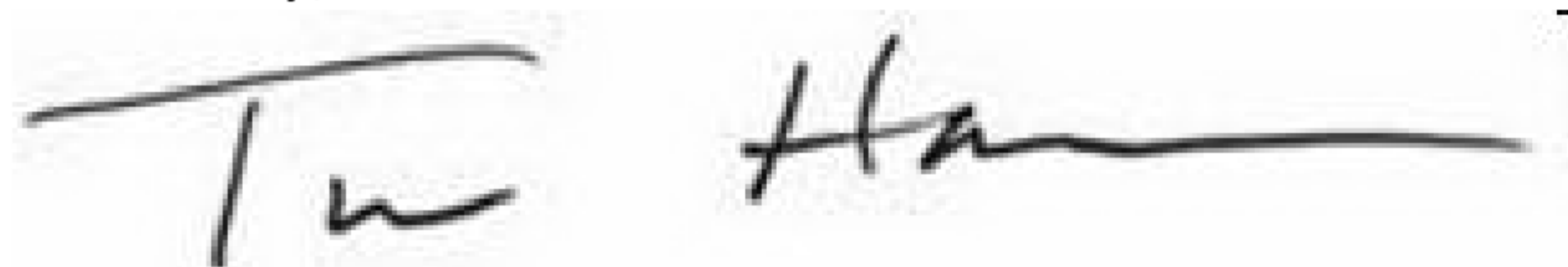
To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", is written over a light gray rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/02/2024
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37090015-1 On December 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 18, 2024. At the time of the survey, there were 4 residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to take corrective actions to comply with the correction orders from a survey completed on September 18, 2024, for failing to provide resident rooms with the minimum window opening meeting the minimum state standard for egress. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 340			

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0 340	Continued From page 2 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 9:40 a.m. the surveyor initiated a follow-up to orders issued pursuant to a survey completed on September 18, 2024. The surveyor emailed licensed assisted living director (LALD)-A to determine if the windows had been replaced in occupied resident rooms A, B, C, and unoccupied resident room E. In an email response dated December 2, 2024, at 11:05 a.m. LALD-A indicated that the windows had not been replaced and that they had not secured a contractor the time of the email. LALD-A stated in an email dated December 5, 2024, at 11:09 a.m. that they have now found a contractor and are now working on window replacement. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{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;	{0 460}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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 3 (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: Not reviewed during this survey.	{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	{0 480}			

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

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{0 630}	Continued From page 5	{0 630}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 630}			
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	{0 650}			

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{0 650}	Continued From page 6 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 7 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	{0 800}			

**6800 QUAIL AVENUE NORTH
BROOKLYN CENTER, MN 55429**

The findings include:

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{0 820}	Continued From page 9 On December 2, 2024, at 9:40 a.m. the surveyor initiated a desk follow-up on orders issued pursuant to a survey completed on September 18, 2024. The surveyor emailed licensed assisted living director (LALD)-A to determine if the windows had been replaced in occupied resident rooms A, B, C, and unoccupied resident room E. In an email response dated December 2, 2024, at 11:05 a.m. LALD-A indicated that the windows had not been replaced and that they had not secured a contractor the time of the email. LALD-A indicated that they were unable to secure a licensed contractor to submit plans prior to initiating the window replacement. LALD-A also indicated that their last architect had stopped responding to them some time ago. LALD-A also indicated in the email that they are still doing the hourly fire watch checks on the resident rooms. In the original survey conducted on September 18, 2024, the facility proposed a fire watch as a corrective measure to maintain the residents' safety until the window replacement was completed. In an email dated December 2, 2024, at 11:27 a.m. the surveyor requested LALD-A provide the fire watch logs for review. LALD-A provide the requested fire watch logs in several emails on December 3, 2024, and December 5, 2024. The fire watch log dated September 18, 2024 - December 02, 2024, indicated the fire watch was not completed consistent with licensee's fire watch policy. The fire watch logs indicated that a fire watch was to be one-hour checks of the occupied resident rooms, however the provided fire watch logs had a significant number of gaps in documentation where the fire watch was not documented. Documentation lacked explanation	{0 820}			

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{0 820}	Continued From page 10 of why there were missing entries in the fire watch logs.	{0 820}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}			
{01060} SS=D	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	{01060}			

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{01060}	Continued From page 11 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01060}			
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be	{01460}			

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{01460}	Continued From page 12 completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01460}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	{01470}			

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{01470}	Continued From page 13 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	{01470}			

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{01500}	Continued From page 15 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			

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{01500}	Continued From page 16	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}			
{01560} SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training	{01560}			

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{01560}	Continued From page 17 requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01560}			
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	{01730}			

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{01730}	Continued From page 18 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	{01760}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/02/2024
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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 19 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: Not reviewed during this survey.	{01760}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2024

Licensee

Bright Path Homes LLC

6800 Quail Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL37090015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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: SL37090015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. An immediate correction order was identified on September 18, 2024, issued for SL37090915-0, tag identification 0820.	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.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 460	Continued From page 1 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 four residents residing at 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) 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:	0 460			

Minnesota Department of Health

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0 460	Continued From page 2 The licensee held an assisted living facility license for a capacity of four residents. During the facility tour on September 16, 2024, at 11:36 a.m., with unlicensed personnel (ULP)-C, no call system was observed in resident rooms to summons staff. During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated the license did not have a system in place for residents to summons staff for assistance. LALD-A stated the licensee's residents were independent and did not require a lot of assistance from staff and if residents required staff assistance, residents could call from their cell phones or call out from their rooms. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 2, 2024, indicated the licensee's services included a call light or bell for residents to summons staff in the event of an emergency or non-emergency. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2024, 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			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630			

Minnesota Department of Health

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0 630	Continued From page 4 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (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: During entrance conference on September 16, 2024, at 12:21 p.m., to 1:38 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included bipolar, hypertension (high blood pressure), type II diabetes, schizo-affective disorder, and traumatic brain injury. R3's Service Plan dated January 18, 2023, indicated R3 received reminders for dressing,	0 630			

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0 630	Continued From page 5 grooming, medication assistance, behavior management, meals, cleaning and laundry. On September 17, 2024, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R3's scheduled morning medications. R3's Vulnerability Assessment dated January 18, 2023, respectively, lacked an individual assessment of the resident's risk of self-abuse. On September 17, 2024, at 12:11 p.m., CNS-B stated the licensee's Vulnerability Assessment in RTasks (web-based electronic health record) included the risk of self-abuse; however, R3's Vulnerability Assessment was completed on paper form which did not address a resident's risk of self-abuse. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. The plan shall contain: -an individualized assessment of the residents susceptibility to abuse by another individual, including vulnerable adults; -risk of abusing other vulnerable adults; -statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; -the plan would be implemented immediately and evaluated at each supervisory visit or more frequently if necessary; and -documentation would include results of the implementation. No further information was provided.	0 630			

Minnesota Department of Health

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0 630	Continued From page 6	0 630			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 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: CNS-B CNS-B had a hire date of June 10, 2022, to supervise and provide direct care services to the licensee's residents. On September 16, 2024, through September 18, 2024, the surveyor observed CNS-B provide services to the licensee's residents. ULP-C ULP-C had a hire date January 5, 2021, to provide direct care services to the residents of the facility. On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. CNS-B and ULP-C's employee records lacked documentation annual performance reviews were being completed. ULP-D ULP-D had a hire date of January 6, 2024, to provide assisted living services to the licensee's residents. R2 and R3's September 2024, medication	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 administration records included ULP-D's initials indicating ULP-D administered R2 and R3's evening scheduled medications. ULP-D's employee record lacked evidence ULP-D received the following training and demonstrated competencies as required: -documentation of requirements for all services; -reports of changes in the client's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various emergency situations; -awareness of commonly used health technology equipment and assistive device; -observing, reporting, and documenting resident	0 650			

Minnesota Department of Health

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0 650	Continued From page 9 status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On September 18, 2024, at 10:08 a.m., licensed assisted living director (LALD)-A stated he was responsible for completing CNS-B's annual performance evaluations and CNS-B was responsible for completing the ULPs annual performance evaluations. LALD-A and CNS-B stated they both completed the necessary employee evaluations but did not know why there were not in CNS-B and ULP-C's employee records. On September 18, 2024, at 11:08 a.m., LALD-A stated he was unable to locate ULP-D's training and competency evaluations. LALD-A stated ULP-D completed required training and competency evaluations with LALD-A and CNS-B in a group training. LALD-A stated employee records were stored offsite and CNS-B went to try and find ULP-D's training records which may have been misfiled. On September 18, 2024, at 11:26 a.m., CNS-B returned and stated she was unable to locate	0 650			

Minnesota Department of Health

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0 650	Continued From page 10 ULP-D's training records and stated she completed ULP-D's competency evaluations in a group training with other new hires. On September 18, 2024, at 11:42 a.m., during a telephone interview, ULP-D stated upon hire, she received orientation training with LALD-A and CNS-B in a group setting with other new hired employees. ULP-D stated orientation training consisted of Educare (online training program), in person with CNS-B on medication and treatments and skills test. ULP-D stated all training was completed on paper except for Educare training which was on completed on the computer. On September 18, 2024, at 11:46 a.m., during a telephone interview, ULP-F stated she took part in the group training with LALD-A, CNS-B, and other new employees. ULP-F stated CNS-B trained staff on medication and treatments, and everyone had to complete a return demonstration and pass a skills test before able to work. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated upon hire and before providing service to residents, all employees attend a general orientation conducted by the licensee. Those providing direct services would complete a competency evaluation as part of the orientation process. The licensee's Personnel Records policy dated August 1, 2021, indicated at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements to include: -documentation of orientation and competency evaluations. The licensee's Performance Evaluation policy	0 650			

Minnesota Department of Health

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0 650	Continued From page 11 dated August 1, 2021, indicated all paid employees, individual contractors and regularly scheduled volunteers providing assisted living services would participate in an annual performance evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health	0 660			

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NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429		
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0 660	Continued From page 12 (MDH), including a history and symptoms screening for active TB for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility's TB risk assessment was completed on October 15, 2023, and the facility was determined to be a low risk level. ULP-C ULP-C had a hire date January 5, 2021, to provide direct care services to the residents of the facility. On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. ULP-C's employee record included a negative chest x-ray for TB dated February 17, 2017; however, lacked evidence ULP-C completed a history and screening for active TB, including a two-step skin test or other blood test. ULP-D ULP-D had a hire date of January 6, 2024, to provide assisted living services to the licensee's residents.	0 660			

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0 660	Continued From page 13 R2 and R3's September 2024, medication administration records included ULP-D's initials indicating ULP-D administered R2 and R3's evening scheduled medications. ULP-D's employee record included a negative chest x-ray dated September 2023; however, lacked evidence ULP-D completed a history and screening for active TB, including a two-step skin test or other blood test. On September 18, 2024, at 12:58 p.m., licensed assisted living director (LALD)-A stated when ULP-C and ULP-D were hire they came with their own TB screening results with no symptom screening for active TB and the licensee did not complete a symptom screening for ULP-C and ULP-D upon hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) was readily available to residents and visitors and contained all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 15 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated Emergency Preparedness Manual, included an undated Hazard Vulnerability Risk Assessment dated October 20, 2023,, generic instructions for staff to follow in case of a fire, severe weather, power outage, hazardous materials, evacuation, and shelter in place. The licensee's Emergency Preparedness Manual lacked documentation the development of policies and procedures to include: -documentation of annual review of the licensee's emergency plan; -a quarterly review of the missing resident policy; -a description of the population served by the licensee; -process for EP cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; -tracking staff and residents; -use of volunteers and other emergency staffing strategies in its emergency plan; -roles under a waiver declared by the Secretary in accordance with section 1135 of the ACT; -a communication plan that included: -a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their	0 680			

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0 680	Continued From page 16 occupancy; -an emergency prep testing requirements to include: -participation in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise; and -an additional annual exercise that may include a second full-scale exercise or mock disaster drill or table-top exercise and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On September 17, 2024, at 1:50 p.m., licensed assisted living director (LALD)-A stated he thought the emergency plan posted on the walls for natural disasters and evacuation met the requirements for an emergency disaster plan. LALD-A stated more information regarding the licensee's EP was online and not accessible to residents or visitor. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have and identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency plan would be reviewed/updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

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0 800	Continued From page 17 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 18, 2024, from approximately 10:05 a.m. to 10:45 a.m., surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed: GENERAL MAINTENANCE: Bedroom E wall and ceiling vents were rusty and full of dust.	0 800			

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0 800	Continued From page 18 Bedroom D had a hole in the wall by the bed. Pop cans, alcohol containers, old food, trash and clothes were scattered all over the floor. Floor and walls soiled. Bedroom A had holes in the walls by the door and bed. Closet door paint coming off. The floors and walls were soiled. Bedroom B had tobacco all over the floor. Soiled walls and floors. Flooring in the main floor hallway was coming up. On September 18, 2024, at 10:50 a.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820			

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0 820	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 18, 2024, at 10:20 a.m. to 10:50 a.m., surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, surveyor asked LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom A: Window measured 33.5 inches clear width, 19 inches clear height, and 636.5 square inches total open area. Bedroom B: Window measured 31 inches clear width, 17 inches clear height, and 527 square inches total open area. Bedroom C: Window measured 31 inches clear width, 15 inches clear height, and 465 square inches total open area.	0 820			

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0 820	Continued From page 20 UNOCCUPIED SLEEPING ROOM: Bedroom E: Window measured 18 inches clear width, 35.5 inches clear height, and 639 square inches total open area. The window in bedroom E did not meet the minimum requirements for opening width. The windows in bedrooms A, B, and C did not meet the minimum requirements for opening height. The windows in bedrooms A, B, C and E did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Smoking Areas: On facility tour with the licensed assisted living director (LALD)-A on September 18, 2024, between 10:20 a.m. and 10:50 a.m. it was observed that cigarette butts were found lying all over the ground in the backyard and by the front steps. The surveyor explained to the LALD-A, that all cigarette butts shall be properly discarded into an	0 820			

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0 820	Continued From page 21 approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by the LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 970			

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0 970	Continued From page 22 the residents). The findings include: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated the licensee's Assisted Living Contract was the same contract used for all residents. R2 and R3's Assisted Living Contract dated August 20, 2024, and January 18, 2023, respectively, included the following sections which included language waiving the facilities liability for health, safety, or personal property of a resident: -Page 13: Indemnification: "The licensee shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Bright Path Homes harmless from any claims or damages unless caused solely by negligence of Bright Path Homes." -Page 11: Miscellaneous Provisions: "The resident agrees the licensee would not be liable to the resident for any personal injury or property damaged (including, without limitation, damage to, or loss of theft of, automobiles or personal property of resident) suffered by the resident, or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of the licensee or its employees or agents." On September 16, 2024, at 3:13 p.m., LALD-A reviewed the licensee's Assisted Living Contract and stated the contract included the above	0 970			

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0 970	Continued From page 23 content and would further review the contract and make necessary changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=D	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:	01060			

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01060	Continued From page 24 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and/or 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) reviewed for a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included bipolar, hypertension (high blood pressure), type II diabetes,	01060			

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01060	Continued From page 25 schizoaffective disorder, and traumatic brain injury. R3's Service Plan dated January 18, 2023, indicated R3 received reminders for dressing, grooming, medication assistance, behavior management, meals, cleaning, and laundry. R3's After Visit Summary indicated R3 was hospitalized from July 23, 2024, to August 5, 2024, for suicide ideation, and decompensated schizoaffective disorder. R3's record lacked evidence a written notice, including the following required content was provided to R3 or R3's representative or notification was provided to the Office of Ombudsman for Long-Term Care for R3's hospitalization of four days or longer: (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. On September 17, 2024, at 12:11 p.m., licensed assisted living director (LALD)-A stated R3's	01060			

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01060	Continued From page 26 record did not include the required information noted above and was aware of the requirement; furthermore, LALD-A was unable to provide an explanation of why a written notice was not provided or notification was not sent to the ombudsman. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing and supervising direct services completed orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (unlicensed personnel (ULP)-D). 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	01460			

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01460	Continued From page 27 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. ULP-D had a hire date of January 6, 2024, to provide assisted living services to the licensee's residents. R2 and R3's September 2024, medication administration records included ULP-D's initials indicating ULP-D administered R2 and R3's evening scheduled medications. ULP-D's employee record included training transcripts with assigned courses; however, ULP-D's training records did not include evidence ULP-D completed orientation to assisted living requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01460			

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01460	Continued From page 28 Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 18, 2024, at 12:09 p.m., LALD-A stated LALD-A was not aware the training assigned to the licensee's employees did not meet the training requirements. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through the licensee would be prepared to provide safe, effective services to all residents through orientation and education program pertinent to the needs of the residents. Upon hire and before providing service to residents, all employees attend a general orientation conducted by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01460			

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01460	Continued From page 29 (21) days	01460			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing	01470			

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01470	Continued From page 30 services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This has 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) 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).	01470			

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01470	Continued From page 31 The findings include: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. CNS-B CNS-B had a hire date of June 10, 2022, to supervise and provide direct care services to the licensee's residents. On September 16, 2024, through September 18, 2024, the surveyor observed CNS-B provide services to the licensee's residents. CNS-B's employee record lacked evidence to indicate CNS-B completed the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: - an overview of Assisted Living 144G statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470			

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01470	Continued From page 32 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. ULP-C ULP-C had a hire date January 5, 2021, to provide direct care services to the residents of the facility. On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. ULP-C's employee record lacked evidence ULP-C completed the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: - an overview of Assisted Living 144G statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services	01470			

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01470	Continued From page 33 the employee would be providing and the facility's category of licensure. On September 18, 2024, at 12:09 p.m., LALD-A stated LALD-A was not aware the training assigned to the licensee's employees did not meet the training requirements. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through the licensee would be prepared to provide safe, effective services to all residents through orientation and education program pertinent to the needs of the residents. Upon hire and before providing service to residents, all employees attend a general orientation conducted by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01500 SS=E	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	01500			

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01500	Continued From page 34 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500			

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01500	Continued From page 35 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 employees performing direct services completed the required annual training for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). 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 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: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. CNS-B CNS-B had a hire date of June 10, 2022, to supervise and provide direct care services to the licensee's residents. On September 16, 2024, through September 18, 2024, the surveyor observed CNS-B provide	01500			

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01500	Continued From page 36 services to the licensee's residents. CNS-B's employee record lacked evidence CNS-B successfully completed annual training as required to include: -infection control techniques; -review of provider's policies and procedures; -hearing loss (optional); and -tuberculosis training. ULP-C ULP-C had a hire date January 5, 2021, to provide direct care services to the residents of the facility. On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. ULP-C's employee record lacked evidence ULP-C successfully completed annual training as required to include: -reporting maltreatment of vulnerable adults or minors; and -review of provider's policies and procedures. On September 18, 2024, at 12:09 a.m., LALD-A stated he was responsible to assigning employee training in Educare (electronic training program). LALD-A stated he was not aware the training assigned to the licensee's employees did not meet the training requirements. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services would complete at least eight hours of education every 12 months of employment. No further information was provided.	01500			

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01500	Continued From page 37	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia training included all the required content for two	01530			

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01530	Continued From page 38 of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP-D.) 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) 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: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. CNS-B CNS-B had a hire date of June 10, 2022, to supervise and provide direct care services to the licensee's residents. On September 16, 2024, through September 18, 2024, the surveyor observed CNS-B provide services to the licensee's residents. CNS-B's employee record lacked evidence CNS-B received the following dementia training: -assistance with activities of daily living (ADL's); -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. ULP-D ULP-D had a hire date of January 6, 2024, to	01530			

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NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01530	Continued From page 39 provide assisted living services to the licensee's residents. R2 and R3's September 2024, medication administration records included ULP-D's initials indicating ULP-D administered R2 and R3's evening scheduled medications. ULP-D's employee record lacked evidence ULP-D received the following dementia training: -assistance with activities of daily living (ADL's); -communication skills; and -person-centered planning and service delivery. On September 18, 2024, at 12:09 a.m., LALD-A stated he was responsible to assigning employee training in Educare (electronic training program). LALD-A stated he was not aware the dementia training assigned to the licensee's employees did not meet the dementia training requirements. The licensee's Dementia Education policy dated August 1, 2021, indicated supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date and direct care employees must have completed at least eight hours of initial education within 160 working hours of the employment start date in the following topics: -An explanation of Alzheimer's Disease and other dementia; -Assistance with activities of daily living (ADL's); -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. 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 potential to affect a large portion or all of the residents).	01560			

Minnesota Department of Health

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01560	Continued From page 41 The findings include: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. CNS-B CNS-B had a hire date of June 10, 2022, to supervise and provide direct care services to the licensee's residents. On September 16, 2024, through September 18, 2024, the surveyor observed CNS-B provide services to the licensee's residents. CNS-B's employee record included training transcripts indicating CNS-B completed 3.25 hours of dementia training; however, lacked documentation CNS-B completed at least eight hours of initial dementia care training on required topics within 120 hours of start date. ULP-D ULP-D had a hire date of January 6, 2024, to provide assisted living services to the licensee's residents. R2 and R3's September 2024, medication administration records included ULP-D's initials indicating ULP-D administered R2 and R3's evening scheduled medications. ULP-D's employee record included training transcripts indicating ULP-D completed 6.75 hours of dementia training; however, lacked documentation ULP-D completed at least eight	01560			

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01560	Continued From page 42 hours of initial dementia care training within 160 hours of start date. On September 18, 2024, at 12:09 p.m., LALD-A stated he assigned Educare training (online training program) to the employee and was not aware the licensee employees were not being assigned the required hours of dementia training. The licensee's Dementia Education policy dated August 1, 2021, indicated supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date and direct care employees must have completed at least eight hours of initial education within 160 working hours of the employment start date in the following topics: -An explanation of Alzheimer's Disease and other dementia; -Assistance with activities of daily living (ADL's); -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730			

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01730	Continued From page 43 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required	01730			

Minnesota Department of Health

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01730	Continued From page 44 content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to include medication storage. R2 R2's diagnoses included schizoaffective disorder, bipolar, anxiety, and chronic obstructive pulmonary disease (COPD). On September 17, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled morning medications. R2's Service Plan dated August 30, 2024, indicated R2 received 24-hour customized living services and to refer to R2's Master Care Plan for services. R2's Master Care Plan dated August 30, 2024, indicated R2 received assistance with medication administration. R2's record lacked a medication management	01730			

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01730	Continued From page 45 plan to include the following required content: -procedures for staff notifying a registered nurse or other licensed health professional when a problem arises with medication management services. R3 R3's diagnoses included bipolar, hypertension (high blood pressure), type II diabetes, schizoaffective disorder, and traumatic brain injury. On September 17, 2024, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R3's scheduled morning medications. R3's Service Plan dated January 18, 2023, indicated R3 received assistance with medication administration. R3's Nurse Reassessment Visit dated August 5, 2024, indicated the nurse set up R3's medications and ULPs administered medications. R3's record lacked a medication management plan to include the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensure that medication refills are ordered on a timely basis; and -procedures for staff notifying a registered nurse or other licensed health professional when a problem arises with medication management services.	01730			

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01730	Continued From page 46 On September 17, 2024, at 11:38 a.m., CNS-B stated she was unable to find documentation in R2 and R3's record the required content noted above. On September 17, 2024, at 12:11 p.m., CNS-B stated the licensee's assessments do not address who was responsible for ordering resident medication and R3's record did not identify the responsible person for ordering resident medications. The licensee's Assessment of Medications policy dated August 1, 2021, indicated based on the results of the assessment, the RN would document an individualized medication management plan, including the following: -a description of medication management services provided; -description of medication storage based on resident need, preferences, risk of diversion and manufacturer's direction; -document procedures; -procedures for verification that medications are administered as prescribed; -procedures for monitoring medication use to prevent complications or adverse reactions; -identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner; -identification of medication management tasks delegated to unlicensed staff; and -procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-C administered medications as prescribed for one of two residents (R2) who received medication management services by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During entrance conference on September 16, 2024, from 12:21 p.m. to 1:38 p.m., licensed	01760			

Minnesota Department of Health

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01760	Continued From page 48 assisted living director (LALD)-A stated the licensee provided medication management services to include medication administration. R2 R2's diagnoses included schizoaffective disorder, bipolar, anxiety, and chronic obstructive pulmonary disease (COPD). R2's Master Care Plan dated August 30, 2024, indicated R2 received assistance with medication administration. R2's record lacked prescriber orders. R2's September 2024 Medication Administration Summary included the following medications were listed and administered: -aspirin 81 milligrams (mg) one tablet daily (for heart health); -daily-vite one tablet daily (for supplementation); -haloperidol 2 mg/milliliter (ml) take 10 ml twice a day (used to treat schizophrenia); -Incruse Ellipta inhaler 62.5 micrograms (mcg) one puff daily (used to treat COPD); -lamotrigine 25 mg two tablets daily (used to treat depression); -losartan potassium 25 mg daily (used to treat high blood pressure); -metoprolol succinate 25 mg one tablet daily (used to treat high blood pressure); -polyethylene glycol powder mix 8.5 grams in liquid and drink daily (used to treat constipation); -haloperidol 5 mg three tables daily at noon (used to treat mood disorders); -pantoprazole 20 mg one tablet 30-60 minutes before dinner (used to treat gastric reflux); and -clonidine 0.1 mg one table at bedtime (used to treat high blood pressure).	01760			

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01760	Continued From page 49 On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C obtain R2's weekly medication planner and pour six pills that were previously set up by clinical nurse supervisor (CNS)-B, into a medication cup. ULP-C filled a syringe with 10 milliliters of liquid Haloperidol then obtain R2's Incruse inhaler and administer R2's medications. After ULP-C administered R2's medications, ULP-C documented in RTasks (web-based electronic health record) R2's medications were administered including polyethylene glycol powder which directed to mix 8.5 grams in liquid; however, ULP-C was not observed to prepare and administer R2's polyethylene glycol powder to R2. ULP-C stated she signed R2's medication administration summary polyethylene glycol power was administered because she thought it was the medication she set up and administered to R2 with the syringe. ULP-C and the surveyor observed the medication storage file cabinet where R2's medications were stored and did not observe R2's polyethylene glycol power. ULP-C stated she did know where R2's polyethylene glycol powder was and furthermore, did not administer polyethylene glycol powder as prescribed. On September 17, 2024, at 11:38 a.m., CNS-B stated R2's polyethylene glycol powder was an active order listed on R2's Medication Administration Summary and should have been administered as directed. CNS-B stated if R2 declined to take any medications, ULP-C should have documented R2 refusal in R2's record. The licensee's Medication Orders policy dated August 1, 2021, indicated the licensee would administer medications as prescribed by the authorized prescriber.	01760			

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01760	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizoaffective disorder, bipolar, anxiety, and chronic obstructive pulmonary disease (COPD). R2's Service Plan dated August 30, 2024,	01820			

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01820	Continued From page 51 indicated R2 received 24-hour customized living services and to refer to R2's Master Care Plan for services. R2's Master Care Plan dated August 30, 2024, indicated R2 received assistance with medication administration. R2's Individualized Medication Management Plan dated September 17, 2024, indicated R2 required assistance with medication management. On September 17, 2024, at 8:00 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. R2's September 2024 Medication Administration Summary included the following medications were listed and administered: -aspirin 81 milligrams (mg) one tablet daily (for heart health); -daily-vite one tablet daily (for supplementation); -haloperidol 2 mg/milliliter (ml) take 10 ml twice a day (used to treat schizophrenia); -Incruse Ellipta inhaler 62.5 micrograms (mcg) one puff daily (used to treat COPD); -lamotrigine 25 mg two tablets daily (used to treat depression); -losartan potassium 25 mg daily (used to treat high blood pressure); -metoprolol succinate 25 mg one tablet daily (used to treat high blood pressure); -polyethylene glycol powder mix 8.5 grams in liquid and drink daily (used to treat constipation); -haloperidol 5 mg three tables daily at noon (used to treat mood disorders); -pantoprazole 20 mg one tablet 30-60 minutes before dinner (used to treat gastric reflux); and -clonidine 0.1 mg one table at bedtime (used to treat high blood pressure).	01820			

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01820	Continued From page 52 R2's record lacked signed orders for R2's medications noted above. On September 17, 2024, at 11:38 a.m., clinical nurse supervisor (CNS)-B stated R2 was a resident and had only been at the facility for two weeks. CNS-B stated R2 when admitted, R2 came with her own medication bottles from the pharmacy which the licensee was currently using for resident medications. CNS-B stated CNS-B spoke with R2's pharmacy and confirmed R2's list of medications and when R2's medications were gone, the pharmacy would re-fill R2's prescriptions and send electronic orders with the medications. CNS-B stated the licensee did not have signed order's in R2's record for R2's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

Type: Full
Date: 09/16/24
Time: 12:00:00
Report: 1031241257

Food and Beverage Establishment Inspection Report

Page 1

Location:

Bright Path Homes Llc
6800 Quail Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038232
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT.
PRINT AND KEEP ILLNESS LOG ON SITE AND UP TO DATE.

Comply By: 09/17/24

4-700 Sanitizing Equipment and Utensils

4-703.11B

**** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL TEMPERATURE DISH MACHINE MEASURED 144F. **DISCONTINUE USE OF DISH MACHINE FOR SANITIZING UNTIL REPAIRED.** CAN BE USED FOR WASH/RINSE. FILL SINK BASIN WITH BLEACH WATER (50-200PPM) AND SANI DIP DISHES AFTER WASHING. ALLOW DISHES TO AIR DRY.

Comply By: 09/17/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).
ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR POSTED.

Comply By: 09/17/24

Type: Full
Date: 09/16/24
Time: 12:00:00
Report: 1031241257
Bright Path Homes Llc

Food and Beverage Establishment Inspection Report

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6-300 Physical Facility Numbers and Capacities

6-301.14A

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

HANDWASH REMINDER SIGN MISSING FROM HANDWASH STATIONIN KITCHEN AND IN BATHROOM. COPY OF REMINDER SIGN SENT WITH REPORT. PRINT AND POST SIGN OR PURCHASE SIMILAR.

Comply By: 10/08/24

6-300 Physical Facility Numbers and Capacities

6-303.11C

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

LIGHT ON STOVE HOOD IS BURNT OUT. REPLACE LIGHT.

Comply By: 10/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

MARBLE COUNTER IN FRONT OF KITCHEN SINK IS BROKEN. REPAIR COUNTER.

Comply By: 10/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

1. MULTIPLE CUPBOARDS AND DRAWER FRONTS ARE TACKY/STICKY. WASH/CLEAN ALL CUPBOARDS AND DRAWER FRONTS UNTIL NO LONGER TACKY.

2. SOME CUPBOARDS AND DRAWERS HAVE FOOD DEBIRS ON INTERIOR SURFACES. REMOVE ITEMS AND CLEAN CUPBOARDS AND DRAWER INTERIORS.

Comply By: 10/08/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: = 200 at Degrees Fahrenheit

Location: Sani Spray

Violation Issued: No

Hot Water: = at 144 Degrees Fahrenheit

Location: Dish Machine

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/Lettuce

Temperature: 38 Degrees Fahrenheit - Location: Refrigerator (white)

Violation Issued: No

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Process/Item: Cold Hold/Deli Turkey
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator (stainless)
Violation Issued: No

Process/Item: Hot Hold/Chx Alfredo
Temperature: 137 Degrees Fahrenheit - Location: Oven in Pan
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	0	5

Nurse Evaluator on site: Sativa Bushey

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare sanitizer bucket or squirt bottle daily. ****RECOMMEND USING CHLORINE.**** Check concentration with test strips (50-200ppm Chlorine) when preparing solution.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Ensure that items stating "KEEP FROZEN" on packaging is being kept frozen, or date mark when placed in refrigerator to thaw. Discard after 7 days.
- Employee food needs to be labeled and separated from residents food.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.
- All Ready-to-eat food to be handled with single-use gloves on.
- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with bleach sanitizer solution (50-200ppm chlorine) to sanitize dishes then air dry, as discussed during inspection.
- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

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Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031241257 of 09/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Massafing Donzo
Person in Charge

Signed:_____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
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