DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 21, 2025

Licensee
Northern Pines Assisted Living Of Pine City LLC
1305 8th Street Southwest
Pine City, MN 55063

RE: Project Number(s) SL30292016

Dear Licensee:

On November 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 3, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

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

CLN

Electronically Delivered

October 10, 2025

Licensee
Northern Pines Assisted Living Of Pine City LLC
1305 8th Street Southwest
Pine City, MN 55063

RE: Project Number(s) SL30292016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30292016-0 On September 2, 2025, through September 3, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on September 3, 2025, issued for SL30292016-0, tag identification 1290. The licensee took action on September 3, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 485		

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0 485	Continued From page 4 and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 2, 2025, at 1:27 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On September 2, 2025, at 1:32 p.m., clinical nurse supervisor (CNS)-B stated three meals per day were included in the resident's basic care package that all residents received. On page eight of the undated Resident Agreement Introduction (assisted living contract) section 6.0 Food Service indicated three nutritional meals are provided each day in the dining room. These meals are included in your (resident) basic rate. Resident assisted living contracts with meal addendums lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On September 3, 2025, at 2:34 p.m., LALD-A stated the licensee did not have a current option for residents to opt out of meals a resident did not want and was not aware the contract could not require a resident to pay for three meals per day. The Minnesota Department of Health Assisted Living Resources and Frequently Asked	0 485		

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0 485	Continued From page 5 Questions (FAQs) website, last updated July 1, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares and medication administration for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 510		

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0 510	Continued From page 6 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management and assistance with ADLs (activities of daily living) to residents at the facility. On September 3, 2025, at 7:38 a.m., the surveyor observed ULP-F enter R5's apartment with gloves on and completed scheduled morning medication administration for R5. Immediately after leaving R5's apartment ULP-F entered R6's apartment. With the same gloved hands, ULP-F assisted R6 out of bed, opened R6's toilet seat, assisted R6 to the toilet, assisted R6 back to R6's wheelchair, flushed R6's toilet, assisted R6 into R6's recliner, picked up the television remote to turn R6's television on, and removed ULP-F's gloves. Without completing hand hygiene, ULP-F entered R7's apartment and put on gloves. ULP-F completed scheduled morning medication administration for R7, including eye drops, and removed ULP-F's gloves. ULP-F returned to R6's room and assisted R6 into R6's wheelchair. Throughout the observation, the surveyor did not observe ULP-F complete hand hygiene in between resident cares or before putting on gloves and after removing gloves. On September 3, 2025, at 10:41 a.m., ULP-G, another ULP working at the facility, stated ULPs	0 510		

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0 510	Continued From page 7 were trained to complete hand hygiene in between glove changes and in between resident cares. On September 3, 2025, at 10:50 a.m., ULP-F stated ULP-F usually brought in ULP-F's own hand sanitizer, however, ULP-F had left the hand sanitizer at home. ULP-F further stated ULP-F should have completed hand hygiene in between resident cares along with before and after glove changes. On September 3, 2025, at 2:27 p.m., clinical nurse supervisor (CNS)-B stated ULPs were expected to complete hand hygiene before and after providing services to a resident. CNS-B further stated hand hygiene was expected to be conducted before putting on gloves and after removing gloves. CNS-B stated the licensee provided infection control training upon hire and annually. In addition, CNS-B stated CNS-B did occasional spot audits for ULPs hand hygiene practices. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated to wash hands before applying gloves and after removing gloves. The licensee's 8.09 Hand Washing policy dated June 11, 2025, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures. In addition, when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning (putting on) gloves and after removing gloves. No further information was provided.	0 510		

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0 510	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R7). 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:	0 630		

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0 630	Continued From page 9 During the entrance conference on September 2, 2025, at 1:27 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included vascular dementia without behavioral disturbance, diabetes, and hypertension (HTN- high blood pressure). R2's Service Plan (PP-NP) dated May 23, 2025, indicated R2 received medication administration, lymphedema wraps, and assistance with bathing, grooming, and dressing. On September 3, 2025, at 6:38 a.m., the surveyor observed unlicensed personnel (ULP)-H provide schedule morning medication administration to R2. R2's Clinical Update Summary (90-day assessment) dated June 16, 2025, included a vulnerability assessment, which addressed R2's risk of being abused and R2's risk to abuse other vulnerable adults. R2's record lacked R2's risk for self-abuse. R7 R7's diagnoses included diabetes, HTN, and chronic kidney disease. R7's Service Plan (Private)- Addendum to Contract dated July 15, 2025, indicated R7 received medication administration, blood glucose monitoring, support stockings, and assistance with bathing. On September 3, 2025, at 7:51 a.m., the	0 630		

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0 630	Continued From page 10 surveyor observed ULP-F provide schedule morning medication administration to R7. R7's Clinical Update Summary (90-day assessment) dated July 25, 2025, included a vulnerability assessment, which addressed R7's risk of being abused and R7's risk to abuse other vulnerable adults. R7's record lacked R7's risk for self-abuse. On September 3, 2025, at 2:54 p.m., LALD-A stated the licensee was aware self-abuse was supposed to be addressed in all resident IAPPs. Clinical nurse supervisor (CNS)-B further stated the assessments CNS-B completed included a question regarding resident self-abuse, however, CNS-B stated CNS-B did not address that question on any resident assessment. The licensee's 6.05 IAPP policy dated June 11, 2025, indicated for purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the	0 775		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 11 requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 finding include: On September 3, 2025, at 10:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following: - The emergency light installed near room 105 did not work when tested by DM-D and the illuminated exit sign was dim at the end of the corridor near resident rooms 123 and 124. Emergency lights and illuminated exit signs must be maintained to illuminate the path of egress in the event of an emergency if power is lost. - There was a hole in the laundry room wall behind the clothes dryer in the assisted living building, requiring repair. - In the assisted living building, 20 minute labeled fire doors were propped open with kick down door stops for rooms 107, 109, and 119. The use of kick down door stops to prop fire doors in the open position prohibits the required operation	0 775		

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0 775	Continued From page 12 and closing feature of the door. - The escutcheon was missing from the fire sprinkler in the closet of room 207. All parts of a listed fire sprinkler assembly must be installed as designed to ensure proper function. - Extension cords were used to supply power in resident rooms 103 and 107, creating a fire hazard. During the facility tour interview, DM-D verified the above listed physical environment observations. - A controlled egress locking system was installed in the dementia care unit. On September 3, 2025, licensed assisted living director (LALD)-A and regional director (RD)-J provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on Spetmeber 3, 2025, at 1:50 p.m., LALD-A and RD-J verified these instructions were not included in the emergency plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 13 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This 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	0 780		

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0 780	Continued From page 14 found to be pervasive). The findings include: On September 3, 2025, at 10:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed in the dementia care unit, one smoke alarm was installed in the common area living room. Smoke alarms were not installed outside each sleeping area in the immediate vicinity of resident bedrooms. During the facility tour interview, DM-D verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 790		

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0 790	Continued From page 15 interview, the licensee failed to maintain the portable fire extinguishers. 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: On September 3, 2025, at 10:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following: - The annual maintenance tags were dated February 2024 on the portable fire extinguishers installed in the following locations: 1. Two fire extinguishers in the dementia care unit corridor. 2. The class K fire extinguisher in the kitchen. Maintenance inspections performed by certified service personnel are required annually. - Monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, DM-D verified	0 790		

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0 790	Continued From page 16 the above listed portable fire extinguisher observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 800		

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0 800	Continued From page 17 On September 3, 2025, at 10:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following: The inspection tag attached to the reduced pressure device (RPZ) in the mechanical room was dated 2022. The inspection tag date was illegible on the RPZ device located on the back of the building. During the facility tour interview, DM-D verified the inspection tag observations. No further inspection documentation was provided. RPZ devices are required to be inspected annually by certified personnel. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 18 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and maintain the fire safety and evacuation plan with required content and provide required drill documentation. 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:	0 810		

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0 810	Continued From page 19 On September 2, 2025, licensed assisted living director (LALD)-A and regional director (RD)-J provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to accurately identify all resident sleeping rooms evident by the following: On September 3, 2025, at 10:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D and licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed evacuation route floor plans were displayed on the walls and number identifiers were posted at resident room doors. The floor plan labeled resident rooms 123 and 124, the numbers posted at these doors were 23 and 24. During the facility tour interview, LALD-A verified the room numbers did not match and explained since the change in ownership, the licensee was in the process of updating all of the room numbers posted on the doors. The number identifiers installed on or at resident room doors must correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee failed to maintain the FSEP evident by the following: - The FSEP directed employees to report fire emergencies to staff that were no longer employed at the facility. - On September 3, 2025, at 10:00 a.m., the	0 810		

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0 810	Continued From page 20 surveyor toured the facility with director of maintenance (DM)-D and licensed assisted living director (LALD)-A. During the tour, the surveyor observed reflective tape was not observed inside fire extinguisher cabinets. The FSEP fire policy dated December 8, 2022, instructed employees to use reflective tape in the fire extinguisher cabinets to identify resident rooms that were vacant and with no signs of fire. - The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. During an interview on September 3, 2025, at 1:50 p.m., LALD-A and RD-J verified the FSEP required revision. DRILLS Record review indicated the licensee failed to maintain evacuation fire drill documentation to support these drills were completed at a frequency of every other month evident by the following: The surveyor requested evacuation drill records from June 2025 to September 2025. Two signature pages were provided, dated June 6, 2025, and August 13, 2025. The June 6, 2025, signature page included thirteen names, was untitled, and did not list any information to support that it corresponded with a fire drill. The fire drill signature page, dated August 13, 2025, lacked the time or shift of the drill, and the simulated drill conditions were not recorded. Additionally, a 2025 fire drill planning matrix was provided. The matrix listed one first shift drill with a date of June 4th. No further information was provided. During an interview on September 3, 2025, at 1:50 p.m., LALD-A and RD-J verified evacuation drill documentation had not been	0 810		

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NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

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0 810	Continued From page 21 maintained. The simulated conditions and time or shift of a fire drill shall be recorded in order to assess the effectiveness of the emergency procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of eight employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility.	01290		

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01290	Continued From page 22 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on September 3, 2025. During the entrance conference on September 2, 2025, at 1:41 p.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-E was hired on June 11, 2025, to provide direct care services to residents at the facility. The licensee's September 2025 MC (memory care) schedule indicated ULP-E was schedule to work September 1, 2, 4, 5, 6, 7, 8, 10, and 11, respectively. ULP-E's employee record lacked a current cleared background study. On September 3, 2025, at 9:00 a.m., the surveyor reviewed the licensee's NETStudy 2.0 Roster printed September 2, 2025, at 2:29 p.m. LALD-A stated ULP-E was a current employee of the licensee and ULP-E worked scheduled shifts unsupervised. LALD-A further stated the licensee's corporate office was responsible for submitting all employee background studies.	01290		

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01290	Continued From page 23 On September 3, 2025, at 9:31 a.m., regional director (RD)-I stated the corporate human resource department was responsible for submitting background studies on the NETStudy 2.0 website. RD-I stated ULP-E did not have an updated background study completed since ULP-E's COVID-19 background study expired on December 31, 2022. RD-I further stated RD-I was not sure if the human resource department would be notified if ULP-E's background study was ineligible since ULP-E's current background study was expired. The licensee's 4.02 Background Studies policy dated June 11, 2025, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees. In addition, no employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study	01290		

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01290	Continued From page 24 subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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	01730		

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01730	Continued From page 25 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 registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01730		

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01730	Continued From page 26 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R4's diagnoses included congestive heart failure (CHF), gastroesophageal reflux disease (GERD-acid reflux), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated July 24, 2025, indicated R4's services included medication administration five times per day. R4's prescriber orders dated July 31, 2025, included two antianxiety, one antihypertensive, two antacids, two anticoagulants, and two to treat pain. R4's record included a prescriber order for antacid 750 milligrams (mg) take one tablet by mouth every two hours as needed. R4's prescriber orders and electronic medication administration record (EMAR) lacked intestinal comfort. On September 3, 2025, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R4's scheduled morning medications. During the observation the surveyor observed bottles of intestinal comfort and antacids on R4's end table. R4 stated R4 took the medication to	01730		

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01730	Continued From page 27 help with acid reflux, bloating, and cramping. ULP-F stated ULPs did not administer intestinal comfort or antacid to R4. R4's Assessment dated July 24, 2025, indicated ALA (ULP) will administer meds (medications) as the PCP (primary care physician) orders [sic] and directed by the RN and med (medication) self-admin (administration) is not applicable. In addition, all meds (medications) are in a secured/locked cupboard in residents [sic] room, room can also be locked. Keys to remain on ALA (ULP) at all times. A face-to-face assessment/review of medication management services was completed by the RN, including review of services and medications (prescriptions, over-the-counter [sic], and supplements). R4's individualized medication management plan lacked documentation R4 was assessed to self-administer and store the antacid and intestinal comfort outside of R4's locked cabinet. In addition, R4's record lacked documentation medication reconciliation had been completed after R4 began taking intestinal comfort. On September 3, 2025, at 2:21 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware R4 was self-administering antacid tablets and intestinal comfort. CNS-B further stated resident medications were supposed to be locked in the resident's cupboard unless an assessment was completed, and the resident was deemed to self-administer and safely store the medication outside of the locked cupboard. CNS-B stated CNS-B should have obtained a prescriber order for R4's intestinal comfort and completed medication reconciliation.	01730		

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01730	Continued From page 28 The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that included documentation of specific resident instructions relating to the administration of medications and a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. The medication management record will be current and updated when there are any changes. In addition, medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 the resident's needs when medication was not	01760		

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01760	Continued From page 29 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of five residents (R5) observed during medication administration. 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 the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R5's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and congestive heart failure (CHF). R5's Service Plan (PP-NP) dated May 28, 2025, indicated R5's services included medication administration three times per day. R5's prescriber orders dated May 21, 2025, included an order for levothyroxine (for thyroid)	01760		

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01760	Continued From page 30 175 micrograms (mcg) - take one tablet by mouth once daily before breakfast. R5's Med (medication) Admin (administration) Summary dated, August 2025, and September 2025, respectively, indicated R5 received levothyroxine 175 mcg tablet by mouth once daily scheduled at 7:00 a.m., along with other medications scheduled at the same time. On September 3, 2025, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-F administer scheduled morning medication administration for R5. The surveyor observed ULP-F administer R5's levothyroxine 175 mcg tablet along with all medications scheduled for 7:00 a.m. ULP-F stated to R5 to go to the dining room for breakfast after R5 was ready. The surveyor did not observe R5 receive levothyroxine 175 mcg tablet before other scheduled medications. On September 3, 2025, at 10:49 a.m., ULP-F stated ULPs were trained to administer medications at the time listed on the resident's electronic medication administration record (EMAR). On September 3, 2025, at 2:25 p.m., clinical nurse supervisor (CNS)-B stated the licensee administered R5's scheduled morning medications all at one time, including levothyroxine. CNS-B further stated the licensee did not receive specific instructions from R5's physician to administer levothyroxine separate from other medications, which resulted in levothyroxine being administered with all other scheduled morning medications.	01760		

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01760	Continued From page 31 The manufacturer instructions for levothyroxine dated August 2022, indicated to administer levothyroxine on an empty stomach, one-half to one hour before breakfast. The licensee's 7.08 Medication Management-Administration and Setup policy dated August 1, 2021, indicated for active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It (MAR) will also include the purpose of the medication and any special instructions if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, the licensee failed to ensure medications were	01880		

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01880	Continued From page 32 secured and permitted access to only authorized personnel for one of one resident (R3). This had the potential to affect all residents receiving refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R3's Assessment dated August 29, 2025, indicated R3's medications will be stored in a locked cabinet in their (R3's) apartment. On September 3, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration for R3. ULP-F stated R3's unopened insulin pens were stored in R3 and R4's unlocked refrigerator and the current refrigerator temperature was unknown. R3's refrigerator contents included five unopened Lantus Solostar 100 unit per milliliter (mL) insulin pens for R3. On September 3, 2025, at 10:45 a.m., ULP-F	01880		

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01880	Continued From page 33 stated any resident who received insulin would store their unopened insulin pens in their private, unsecured refrigerator. ULP-F further stated ULPs do not check the temperature of resident refrigerators that store resident medication. On September 3, 2025, at 2:10 p.m., R3 stated R3's unopened insulin pens were stored in R3's unlocked refrigerator and R3 was not sure if ULPs monitored R3's refrigerator temperature. On September 3, 2025, at 2:29 p.m., CNS-B stated unopened resident insulin pens were stored in the resident's unsecured, private refrigerators. CNS-B further stated the licensee would not know if the unopened insulin pens were being stored per manufacturer instructions since the licensee did not monitor the resident's refrigerator temperatures. CNS-B stated anyone who entered R3's apartment would have access to R3's unopened insulin pens stored in R3's refrigerator. The manufacturer's instructions for Lantus dated May 2019, indicated to store unused Lantus in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F. Do not allow Lantus to freeze. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). In addition, medications managed inside a resident's private "living space" [sic] must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a locked drawer, cabinet, etc [sic].	01880		

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01880	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of five residents (R3, R7). 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 the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living	01890		

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01890	Continued From page 35 director (LALD)-A stated the licensee provided medication management to residents at the facility. R3 On September 3, 2025, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-F complete scheduled morning medication administration for R3, which included administration of Lantus 100 units per milliliter (mL) insulin pen. R3's Lantus insulin pen was not labeled with an open date or expiration date. ULP-F stated the ULP who opened R3's insulin pen forgot to label R3's insulin pen with the open date. R7 On September 3, 2025, at 7:51 a.m., the surveyor observed ULP-F complete schedule morning mediation administration for R7, which included administration of R7's Timolol 0.5% eye drops and Humalog insulin pen. R7's Timolol eye drops, and Humalog insulin pen were not labeled with an open date or expiration date. ULP-F stated R7's insulin pen was not labeled and ULPs never labeled any eye drops with an open date or expiration date. On September 3, 2025, at 10:40 a.m., ULP-G stated ULPs were trained to write the open date in permanent marker for time sensitive medications. On September 3, 2025, at 2:22 p.m., clinical nurse supervisor (CNS)-B stated all time sensitive medications, including insulin pens and eye drops, were required to have an open date and expiration date written on the yellow labels provided by the licensee. CNS-B further stated	01890		

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01890	Continued From page 36 the licensee had a chart posted in the office for ULPs to refer to for expiration dates of time sensitive medications. The manufacturer's instructions for use of Lantus dated May 2019, indicated to discard the Lantus insulin pen 28 days after opening, even if the insulin pen still contains Lantus. The manufacturer's instructions for Humalog dated May 2015, indicated to discard the Humalog insulin pen 28 days after opening, even if the insulin pen still contains Humalog. The manufacturer's instructions for the use of Timolol eye drops dated June 2020, indicated to discard Timolol eye drops four weeks after opening, even if the bottle still contains Timolol. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must	02040		

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02040	Continued From page 37 be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment of the physical environment on and around the property with mitigation factors. 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). Findings include: On September 3, 2025, a safety risk assessment for the physical environment was requested by the surveyor. A hazard vulnerability assessment was provided by regional director (RD)-J. The assessment had been completed for emergency preparedness and was not specific to the physical environment to protect dementia care residents from harm. During an interview on September 3, 2025, at 1:50 p.m., RD-J verified a physical environment safety risk assessment on and around the property had not been completed.	02040		

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02040	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities;	02170		

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NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

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02170	Continued From page 39 (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for one of one resident (R2) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 2, 2025, at 1:27 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included vascular dementia without behavioral disturbance, diabetes, and hypertension (HTN- high blood pressure). R2's Service Plan (PP-NP) dated May 23, 2025, indicated R2 received medication administration, lymphedema wraps, and assistance with bathing, grooming, and dressing.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 40 On September 3, 2025, at 6:38 a.m., the surveyor observed unlicensed personnel (ULP)-H provide schedule morning medication administration to R2. R2's Clinical Update Summary (90-day assessment) dated June 16, 2025, included an evaluation of activity capabilities and behavior, however, lacked evaluation for the following areas: -past and current interests; -emotion and social needs and patterns; and -adaptations necessary for the resident to participate. In addition, R2's record lacked an individualized activity plan with structured and non-structured activities specific for R2 On September 3, 2025, at 10:42 a.m., ULP-G stated ULPs working in the dementia care dementia care unit complete a group activity daily based on the activity schedule posted. On September 3, 2025, at 2:27 p.m., LALD-A stated an activity schedule was posted in the dementia care for ULPs to complete the activity daily with residents. On September 3, 2025, at 3:02 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware of all the requirements for a resident's individualized activity evaluation and activity plan. The licensee's 3.05 ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated June 11, 2025, each resident must be evaluated for activities according to the licensing rules of the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 41 facility. In addition, the evaluation must address the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the policy indicated an individualized activity plan must be developed for each resident based on their activity evaluation including structured and non-structured activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-F) observed administering	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(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
02320	Continued From page 42 medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 2, 2025, at 1:31 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R5's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and congestive heart failure (CHF). R5's Service Plan (PP-NP) dated May 28, 2025, indicated R5's services included medication administration three times per day. R5's prescriber orders dated May 22, 2025, included an order for fluticasone proplon [sic]-salmeterol (Advair) (for breathing) 250-50 micrograms (mcg) diskus inhaler- inhale one puff by mouth every 12 hours. R5's Med (medication) Admin (administration) Summary-Actual- Month dated August 2025, and September 2025, respectively, indicated R5 was administered Advair Diskus 250-50 mcg- inhale one puff twice daily. Have resident rinse out	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN PINES ASSISTED LIVING OF PINE	1305 8TH STREET SW PINE CITY, MN 55063

(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
02320	Continued From page 43 mouth after use, spit out water, do not swallow. On September 3, 2025, at 7:38 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R5. ULP-F handed R5 the Advair Diskus inhaler and R5 inhaled one puff form the Advair Diskus inhaler. ULP-F returned the Advair Diskus to R5's locked cabinet and left R5's apartment. The surveyor did not observe ULP-F offer R5 water to rinse and spit after inhalation of the Advair Diskus inhaler. On September 3, 2025, at 10:41 a.m., ULP-G stated ULPs were trained to follow instructions listed on the resident's electronic medication administration record (EMAR). On September 3, 2025, at 10:48 a.m., ULP-F stated ULP-F did not offer R5 water to rinse and spit after the Advair Diskus administration since refused to rinse and spit after the Advair Diskus administration in the past. On September 3, 2025, at 2:24 p.m., clinical nurse supervisor (CNS)-B stated ULPs were trained to offer residents to rinse and spit after certain inhaler administrations and the instructions were listed on the resident's EMAR. CNS-B further stated CNS-B had provided education to residents about the importance to rinse and spit after using certain inhalers. The manufacturer's instructions for Advair Diskus dated August 2020, indicated to rinse mouth with water after you have used the Advair Diskus inhaler and spit the water out. Do not swallow the water. The licensee's 7.15 Medication and Treatment-	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30292	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 44 Administration and Delegation policy dated June 11, 2025, indicated an RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the residents' [sic] record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

NORTHERN PINES ASSISTED LIVING
1305 8TH STREET SW
Pine City, MN 55063
Pine County
Parcel:

Phone:

License Info

License: HFID 30292

Risk:
License:
Expires on:
CFPM: CATHY MARY TAVER
CFPM #: CFPM-26770; Exp: 12/12/2027

Inspection Info

Report Number: F1016251070
Inspection Type: Full - Single
Date: 9/2/2025 Time: 1:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: SPRAY BOTTLE IN "MEMORY CARE" KITCHEN DID NOT HAVE A LABEL. LABEL ALL SPRAY BOTTLES.
Comply By: Complied On Site Originally Issued On: 9/2/2025

Food & Beverage General Comment

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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

I acknowledge receipt of the Duluth District Office inspection report number F1016251070 from 9/2/2025

CATHY MARY TAVER
KITCHEN MANAGER

Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

NORTHERN PINES ASSISTED LIVING
Pine City
County/Group: Pine County

Inspection Info

Report Number: F1016251070
Inspection Type: Full
Date: 9/2/2025
Time: 1:00 PM

Food Temperature: Product/Item/Unit: GRAPES**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: WATER**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN**; Temperature Process:** Cold-Holding
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

NORTHERN PINES ASSISTED LIVING
Pine City
County/Group: Pine County

Inspection Info

Report Number: F1016251070
Inspection Type: Full
Date: 9/2/2025
Time: 1:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 162 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No