STATE LICENSING COMPLIANCE REPORT

Report #: HL370902240C

Date Concluded: December 1, 2025

Name, Address, and County of Facility Investigated:
Bright Path Homes
6800 Quail Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator
George Niemeyer
Engineering Specialist

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37090	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6800 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL370902240C On November 13, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 5 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL370902240C, tag identification 630, 780, 790, 800, 810, 900, and 1620.	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.	
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 create an individualized abuse prevention plan (IAPP) for one of five residents (R5). This had the ability to affect all residents. Additionally, the licensee failed to ensure IAPPs included specific measures to be taken to minimize the risk of abuse to themselves and others for four of five residents (R1, R2, R3, R4). 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: R1 R1 was admitted to the licensee January 18, 2023. R1's diagnoses included schizoaffective disorder and bipolar disorder. R1's service plan	0 630		

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0 630	Continued From page 2 dated November 25, 2025, indicated R1 received assistance with managing behaviors including property destruction, as well as verbal and physical aggression. R1's assessment dated July 1, 2025, indicated R1 had "extreme" behaviors, but failed to specifically identify what those behaviors were. R1 Incident Reports An incident report dated November 19, 2024, indicated R1 started a fire in his room, and the fire alarm in his room went off. R1 called 911, law enforcement arrived, and R1 requested to go to the hospital. Staff notified management. The incident report did not include any further action or intervention taken by the licensee. An incident report dated September 16, 2025, at 10:00 p.m., indicated R1 went into the kitchen, took off his pants, and urinated on the kitchen floor after a previous incident with staff. The staff response or action take included cleaning the floor and notifying the supervisor and nurse. The incident report did not include any intervention or further action taken by the licensee. An incident report dated September 17, 2025, at 11:30 a.m., indicated R1 asked staff to call for an ambulance due to having suicidal thoughts. Staff called for an ambulance, and R1 went to the hospital. Staff notified management. The incident report did not include any further action taken by the licensee. An incident report dated October 4, 2025, at 12:00 p.m., indicated R1 displayed extreme agitation and destroyed one of the kitchen cabinets. The staff response or action included asking him to stop. The incident report indicated a nurse or supervisor had been notified. The	0 630		

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0 630	Continued From page 3 incident report did not include any other interventions or action taken by the licensee. R1 Progress Notes A progress note, titled Behaviors, dated September 17, 2025, at 1:20 p.m., indicated staff reported that on September 16, 2025, R1 had been banging chairs on the table and acting extremely aggressive toward staff. Staff tried to redirect him, but R1's behaviors continued. Staff went outside to get away from R1, but he went after the staff member, chasing her with a chair. R1 later took rocks and threw them through the window, breaking it. Staff called 911, but R1 continued after law enforcement left. A progress note, titled Psych Follow Up, dated September 22, 2025, at 4:15 p.m., indicated R2 continued to have extreme behaviors of destroying properties and aggression toward staff and others. The note indicated staff would implement new medication orders and continue to manage behaviors. A progress note, titled Punching Medication Cabinet, dated October 30, 2025, at 11:35 a.m., indicated R1 began punching and kicking the medication cabinet. Staff intervened by telling him to stop. R1 Law Enforcement Reports A law enforcement Call For Service Report, dated February 7, 2025, indicated R1 had been violent towards another resident and had been trying to break down the resident's door. R1 had a knife but gave it to law enforcement. A law enforcement Call For Service Report, dated February 19, 2025, indicated R1 had been smoking in the facility, hitting things against walls,	0 630		

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0 630	Continued From page 4 and broke the window in his room using a broom. A law enforcement Call For Service Report, dated August 29, 2025, indicated R1 had been hallucinating and yelling about voices for about one week. R1 voluntarily went to the hospital. A law enforcement report, dated November 13, 2025, indicated R1 became upset with a staff member, grabbed a pole from the bedroom, and began hitting her. The licensee provided the Pre-termination Meeting Request/Notice for R1's termination, dated September 22, 2025, which identified the reasons for R1's proposed termination. R1's behaviors included refusing medications, frequent hospitalizations, property destruction, and bullying female staff. The notice indicated measures taken to improve behaviors were R1 receiving medication injections, but insurance stopped for those; the licensee would consider having male staff instead of female staff ; R1 wanted to take his oral medications at 11:00 a.m., but registered nurse (RN)-B wanted R1 to take them before 10:00 a.m. because it was a better schedule. R1's record lacked documented efforts to resolve the insurance issue with R1's provider to resume medication injections. R1's IAPP, dated September 24, 2025, identified R1 as being physically and verbally aggressive towards other residents. The IAPP indicated R1 sometimes turned on the stove, then left the area. The IAPP did not include R1's unsafe smoking practices. The IAPP failed to include specific measures to help reduce the risk of R1 abusing other residents. R1's IAPP was not updated with specific interventions after incidents of unsafe smoking and physical violence towards others	0 630		

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0 630	Continued From page 5 that occurred after September 24, 2025. During an observation November 13, 2025, at 10:16 a.m., R1's room had burn marks near the window, cigarette ash throughout, and smelled of smoke. Images taken during this time showed a burn hole in R1's blanket, cigarette ash on the floor, dresser and shoes, and burn marks on the windowsill. During email correspondence November 13, 2025, at 5:02 p.m., RN-B indicated the smoking assessment and vulnerability assessment had not been filled out for R1, as she was still working on it. During an interview on November 24, 2025, at 10:05 a.m., unlicensed personnel (ULP)-G stated R1 smoked in his room almost daily. Sometimes, he would light paper on fire. When staff went into his room, R1 stated he wanted to burn the place down. When staff saw him smoking, they tried telling him it was not safe to smoke or light paper on fire. He continued with the behavior. Staff would give the information to licensed assisted living director (LALD)-A, or sometimes complete incident reports. Then, staff would "just let it be." R2 R2 was admitted to the licensee May 5, 2021. R2's diagnoses included schizoaffective disorder and agitation. R2's service plan dated November 25, 2025, indicated R2 received assistance with managing behaviors including agitation, verbal aggressive, and self-injurious behavior. R2's IAPP, dated October 31, 2025, identified R2 as being at risk to be abused, at risk to abuse other vulnerable adults, and at risk for self-abuse	0 630		

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0 630	Continued From page 6 related to a history of suicide or thoughts of suicide. The IAPP failed to include specific measures to help reduce the risk of R2 abusing other residents, self-abuse, or being abused by others. R3 R3 was admitted to the licensee August 30, 2023. R3's diagnoses included disruptive mood dysregulation disorder, anxiety, and a history of abuse in childhood. R3's service plan dated November 25, 2025, indicated R3 received safety checks and assistance managing behaviors including agitation and anxiety, as well as verbal and physical aggression. R3's IAPP, dated September 17, 2025, identified R3 as at risk to be abused and at risk to abuse other vulnerable adults. The IAPP indicated R3 could be physically aggressive and extremely verbally aggressive with other residents. R3's IAPP failed to include specific measures to help reduce the risk of R3 abusing other residents or being abused by others. R4 R4 was admitted to the licensee January 14, 2025. R4's diagnoses included traumatic amputation of the right lower leg and Parkinson's disease. R4's service plan dated November 25, 2025, indicated R4 received assistance with managing behaviors including verbal and physical aggression, agitation, anxiety, and depression. R4's IAPP, dated October 28, 2025, identified R4 as at risk to be abused, at risk to abuse others, and as having a history of suicide or thoughts of suicide. The IAPP failed to include specific	0 630		

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0 630	Continued From page 7 measures to help reduce the risk of R4 abusing other residents, being abused by others, or self-abuse. R5 R5's date of admittance was unknown. R5's diagnoses were unknown. During an observation November 13, 2025, at 11:20 a.m., Room E, a bedroom on the lower level of the licensee, contained R5's personal belongings. During an interview November 13, 2025, at 11:12 a.m., LALD-A stated R5, an acquaintance, stayed in Room E for a while. R5 had temporarily been staying at the licensee off and on. During an interview November 13, 2025, at 11:20 a.m., R5 stated LALD-A had been helping him out with a place to stay. R5 stated he had just been at the licensee in the morning. The licensee failed to obtain any information on R5, including date of admittance and diagnoses. Additionally, the licensee failed to develop an IAPP for R5, including identifying R5's risk for abusing others. During an interview on November 26, 2025, at 9:02 a.m., ULP-C stated R1 always smoked in his room. The staff told him not to smoke in his room, but it did not really work. ULP-C stated R1 also always played with fire in his room, including starting a fire in his room in November 2024. ULP-C identified this as the only fire they knew about, but not everyone might report if there had been another fire. Additionally, R1 would leave	0 630		

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0 630	Continued From page 8 the stove on. ULP-C stated they had to watch him while he was near the stove and tell him to leave from the stove. During an interview on November 26, 2025, at 12:33 p.m., RN-B stated when a resident admitted, she filled out the vulnerability assessment, including the questions determining if they were at risk to abuse others or at risk to be abused by others, as well as interventions to prevent the abuse from happening. The licensee-provided policy titled Vulnerable Adult, dated August 1, 2021, indicated the licensee would be responsible for assessing the vulnerability status of each resident upon admission. The policy indicated the resident's risk of abusing other vulnerable adults would also be assessed. The policy indicated an IAPP would be established for each vulnerable adult for whom assisted living services would be provided. The plan would contain the resident's risk of abusing other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780		

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0 780	Continued From page 9 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 functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 10 The findings include: On November 13, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-C. The surveyor requested ULP-C to initiate a test of the smoke alarms throughout the facility. The following was observed. None of the smoke alarms in the facility were interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. The smoke alarm in the first floor common hallway failed to operate when ULP-C attempted to test it. Fire and life safety systems shall be maintained in an operable condition at all times. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 790 SS=F	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	0 790		

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0 790	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. 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 the potential to affect a large portion or all of the residents). The findings include: On November 13, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-C. The following was observed. The portable fire extinguishers throughout the facility were equipped with service tags that indicated they were last serviced September 2024. Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. The portable fire extinguisher in the basement living room was not mounted to the wall and was sitting on the floor in the corner of the room. Portable fire extinguishers shall be permanently	0 790		

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0 790	Continued From page 12 mounted in a conspicuous location at least four inches off the floor and no higher than five feet above the floor to the top of the extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=I	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 5 of 5 residents (R1, R2, R3, R4, R5). This deficient condition had the potential to affect all staff, residents, and visitors. 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	0 800		

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0 800	Continued From page 13 has affected or has potential to affect a large portion or all of the residents). The findings include: On November 13, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-C. The following was observed. In resident room A there was heavy staining/soiling on the walls, floor, mattress, bedding, and furniture. There were multiple holes in the walls. There were food remnants, food packaging, drink containers, and a brown sticky substance that appeared to be consistent with spilled soda on the walls, floor, mattress, bedding and furniture creating an unsanitary condition throughout the resident room. In resident room B there were several empty boxes of beer that were being used as waste receptacles on the bed. There were food remnants, and food packaging throughout the room causing an unsanitary condition. In resident room C there was what appeared to be fecal matter on the floor next to the closet. The room smelled strongly of urine and feces. There was heavy staining/soiling on the walls, floor, mattress and furniture. There were food remnants, food packaging throughout the resident room causing an unsanitary condition. The door leading into resident room C was damaged. There were several holes on the hinge side of the door on the lower half. In resident room L there were food remnants, food packaging, and drink containers throughout the room causing an unsanitary condition. There were multiple holes in the walls and resident	0 800		

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	37090	A. BUILDING: _____ B. WING _____	C 11/13/2025

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0 800	Continued From page 14 room door. The handle to operate the egress window was broken off and missing. The light fixture was missing the protective globe covering. In resident room E the light fixture was missing the protective globe covering. In the first floor bathroom there was an unfinished drywall patch next to the light switch, and the toilet paper holder was missing half of the holder. In the lower level bathroom, the medicine cabinet with mirror was not secured to the wall and was hanging away at the top by approximately 2.5 inches. There was a hole in the wall next to the toilet. There was a black mold like substance in the shower and on the glass shower door. The bathroom vent fan was not operational. In the lower level laundry room, there were cabinets installed with a countertop. The bases of the cabinets were delaminating and showing signs of water damage. In the lower level living room, there was a hole in the wall behind the door leading to the laundry room. In the kitchen there were several cabinet doors that had holes in them or were missing the center inlay of the door. There was a broken window on the east side of the kitchen near the dining room table. On the front door to the facility on the hinge hand side of the entry door there was missing brickmold on the lower portion of the door. The licensee provided the Pretermination Meeting Minutes for R1's termination, dated September	0 800		

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0 800	Continued From page 15 29, 2025. This document indicated the licensee had been hesitant to do repairs because R1 would come back to break them again. During an interview on November 18, 2025, at 2:05 p.m., case manager (CM)-D for R2 stated he has had problems with the facility management for a while. CM-D stated the facility R2's room was not clean, not enough staff and the facility has needed to repair their roof. CM-D stated licensed assisted living director (LALD)-A always wants to increase the waiver payment rate for R2's services and CM-D stated it is not appropriate to use the money for R2's services to repair items in the home, that is the expense of LALD-A. During an interview on November 19, 2025, at 9:01 a.m., CM-E for R3 stated she recently had R3 added as a client. She has seen photos of the state of R3's room taken in September 2025 and had concerns about the cleanilness. R3 has rules set up in place for the facility to help R3's concerns of people stealing items when they clean that R3 will be present during the cleaning, however that has not taken place by the facility. CM-E stated she's been working on find a new place for R3 to move to for a month. During an interview on November 19, 2025, at 9:15 a.m., CM-F for R4 stated she has been looking for a new place for R4 to move to due to concerns about care and issues with R4's room being unclean. During an interview on November 26, 2025, at 12:33 p.m., registered nurse (RN)-B stated LALD-A planned to leave the holes in the walls in R1's room until after R1 moved out. RN-B stated R1 would keep putting holes in his walls, so the	0 800		

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0 800	Continued From page 16 licensee is just going to work on relocation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. 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: On November 13, 2025, at 12:36 p.m., the surveyor requested that unlicensed personnel (ULP)-C provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. At 12:43 p.m. ULP-C stated that the FSEP, training for staff and residents on the FSEP, and evacuation drills were not available on site and that licensed assisted living director (LALD)-A would provide them via email. ULP-C declined to provide a timeline for when the requested documentation would be provided. As of November 25, 2025, at 3:00 p.m. no documents have been provided for review by LALD-A.	0 810		

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0 810	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	0 900		

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0 900	Continued From page 19 Based on observation, interview, and record review, the licensee failed to execute an assisted living contract before providing housing for one of five residents (R5). 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: R5's date of admittance was unknown. R5's diagnoses were unknown. R5 lacked a signed assisted living contract. During an observation November 13, 2025, at 11:20 a.m., Room E, a bedroom on the lower level of the licensee, contained R5's personal belongings. During an interview November 13, 2025, at 10:51 a.m., registered nurse (RN)-B stated Room E had been vacant. During an interview November 13, 2025, at 11:12 a.m., licensed assisted living director (LALD)-A stated R5, an acquaintance, stayed in Room E for a while. R5 had temporarily been staying at the licensee off and on. During an interview November 13, 2025, at 11:20 a.m., R5 stated LALD-A had been helping him out with a place to stay. R5 stated he had just been at the licensee in the morning.	0 900		

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0 900	Continued From page 20 During email correspondence November 14, 2025, at 1:51 p.m. LALD-A indicated R5 had not been a resident and had not been a renter. R5 "just used that room to get himself temporarily situated. He didn't sign anything to be there." The licensee's resident roster failed to include R5. The licensee-provided policy titled Notifications, dated August 1, 2021, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident. TIME PERIOD FOR CORRECTION: Two (2) days.	0 900		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01620		

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01620	Continued From page 21 planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an assessment as needed based on the needs of the resident, for one of five residents (R1). The licensee failed to complete a smoking assessment, assessing for smoking safety	01620		

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01620	Continued From page 22 factors. The licensee also failed to complete a change in condition assessment after a hospital visit due to suicidal ideation 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 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 an observation on November 13, 2025, at 10:16 a.m., R1's room had burn marks near the window, cigarette ash throughout, and smelled of smoke. Images taken during this time showed a burn hole in R1's blanket, cigarette ash on the floor, dresser and shoes, and burn marks on the windowsill. R1 was admitted to the licensee on January 18, 2023. R1's diagnoses included schizoaffective disorder and bipolar disorder. R1's service plan, dated November 25, 2025, indicated R1 received assistance with managing behaviors including property destruction and self-injurious behavior. An incident report, dated November 19, 2024, indicated R1 started a fire in his room, and the fire alarm in his room went off. R1 called 911, law enforcement arrived, and R1 requested to go to the hospital. Staff notified management. The incident report did not include any further action or intervention taken by the licensee. A law enforcement Call For Service Report, dated February 19, 2025, indicated R1 had been	01620		

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01620	Continued From page 23 smoking in the facility, hitting things against walls, and broke the window in his room using a broom. R1's assessment dated July 1, 2025, indicated R1 had "extreme" behaviors, but failed to specify what those behaviors were. The assessment failed to address R1's smoking, including his unsafe smoking habits and smoking in his room. An incident report dated September 17, 2025, at 11:30 a.m., indicated R1 asked staff to call for an ambulance due to having suicidal thoughts. Staff called for an ambulance, and R1 went to the hospital. Staff notified management. The incident report did not include any further action taken by the licensee. R1's record lacked a change in condition assessment related to R1's suicidal thoughts and hospital visit. During an interview on November 13, 2025, at 12:25 p.m., registered nurse (RN)-B stated R1 has been a heavy smoker. R1 knew not to smoke in the building but had been uncooperative. Smoking inside had been a behavior the licensee had been managing. Licensed assisted living director (LALD)-A served a termination notice to R1 for smoking. During an interview on November 13, 2025, at 12:39 p.m., R1 stated staff did tell him to go outside to smoke. R1 stated he had been on probation through LALD-A about a month prior, but that ended. The probation meant if he misbehaved over the course of thirty (30) days, he would be kicked out. The probationary period had been due to him writing on the walls. R1 stated he did not have an active discharge notice.	01620		

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01620	Continued From page 24 During email correspondence November 13, 2025, at 5:02 p.m. RN-B indicated the smoking assessment had not been completed, as she was still working on it. During an interview November 26, 2025, at 9:02 a.m., unlicensed personnel (ULP)-C stated R1 always smoked in his room. ULP-C stated R1 lit a fire in his room November 2024, and he always played with fire in his room. ULP-C stated if there were any other fires, some staff might not have reported it. The licensee's policy titled, Comprehensive Nursing Assessment, dated August 1, 2021, indicated the registered nurse (RN) would conduct a comprehensive assessment, including addressing lifestyle preferences, which included smoking and smoking safety factors. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		