Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 14, 2026

Licensee
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429

RE: License Number 423103
Health Facility Identification Number (HFID) 24780
Project Number(s) SL24780016

Dear Licensee:

On February 11, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed November 26, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective April 14, 2026.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

At the time of this follow-up survey completed on February 11, 2026, we identified the following violation(s):

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $1,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is $1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per 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).

IMPOSITION OF FINES:

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

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.

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	R 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH ISSUED OR RE-ISSUED ORDERS INITIAL COMMENTS SL24780016-2 On February 9, 2026, through February 11, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 12, 2025. At the time of the survey, there were eleven (11) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} 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, existing floor, wall, and ceiling finishes are	{0 480}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.	
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Cigarettes were not disposed of in a proper manner and discarded smoking materials were located on the ground and on the back porch of the property. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 775		

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0 775	Continued From page 3 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 February 10, 2026, from approximately 2:45 p.m. to 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following deficient condition: A significant number of cigarette butts were located scattered on the ground throughout the rear yard. There were provided smoking receptacles, but the majority of the cigarette butts were not properly discarded into these receptacles and were left on the ground near the buildings, along the walkways, and near picnic table areas. The improper disposal of smoking materials presents a fire hazard and all smoking materials should be disposed of in approved receptacles. On February 10, 2026, the surveyor explained to LALD-A the requirements for proper disposal of smoking materials. LALD-A stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 4 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	{0 810}		

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{0 810}	Continued From page 5 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by:	{0 830}	Not reviewed during this survey.	

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 21, 2025

Licensee
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429

RE: Conditional License Number 418519
Health Facility Identification Number (HFID) 24780
Project Number(s) SL24780016 and HL247809430C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on September 12, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 90-day conditional license, pending appeal.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on November 26, 2024, found not corrected at the time of the September 12, 2025, follow-up survey subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1- $500.00
0720-Access To Records-144g.43 Subd. 2- $500.00
1060-Emergency Relocation-144g.52 Subd. 9- $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)- $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)- $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8- $500.00
1880-Storage Of Medications-144g.71 Subd. 19- $500.00
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5- $500.00

The details of the violations noted at the time of this follow-up completed on September 12, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up completed on September 12, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1820-Prescriptions-144g.71 Subd. 13
1970-Treatment And Therapy Orders-144g.72 Subd. 6
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $1,000.00

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $5,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject

to appeal.
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:
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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. If you submit a request for a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

CONDITIONAL LICENSE ISSUED:
MDH will issue Amazing Love Assisted Living a conditional assisted living facility license for 90 calendar days, pending appeal. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Amazing Love Assisted Living is in substantial compliance.

The following conditions apply on the conditional assisted living facility license, pending appeal:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Amazing Love Assisted Living will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Amazing Love Assisted Living must provide the Department:

   i. A list of the names and birthdates of any individuals Amazing Love Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents:
      1. Name and birthdate of each resident
      2. Current payment source for services
      3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
      4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Amazing Love Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Amazing Love Assisted Living provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Amazing Love Assisted Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Amazing Love Assisted Living and MDH must review the RN's credentials and approve the selection. Amazing Love Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Amazing Love Assisted Living in an effort to help Amazing Love Assisted Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Amazing Love Assisted Living will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Amazing Love Assisted Living and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Amazing Love Assisted Living to correct the violations cited during the follow-up survey as well as to determine the overall practice of Amazing Love Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up survey: At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

g. Corrective Action Plan: Amazing Love Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens

v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Amazing Love Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Amazing Love Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions from Amazing Love Assisted Living's assisted living facility license, and Amazing Love Assisted Living will correct any outstanding violations identified during the survey. If Amazing Love Assisted Living is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. § 144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. Per Minn. Stat. § 144G.20, Subd. 14, the request for a hearing must be made in writing and must contain a brief and plain statement describing every matter or issue contested and contain a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor.

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

If you request a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

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 Jess Schoenecker directly at: 651-201-3789.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	R 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL24780016-1 HL247809430C On September 10, 2025, through September 12, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey and complaint investigation completed on November 26, 2024. At the time of the survey, there were eleven (11) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued. On September 11, 2025, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level remain unchanged.	{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.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	{0 250}		

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	24780	A. BUILDING: _____ B. WING _____	R 09/12/2025

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{0 250}	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}		

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initiation of this survey on September 10, 2025, at 9:30 a.m., licensed assisted living	{0 250}		

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{0 250}	Continued From page 3 director (LALD)-A stated the licensee provided medication and treatment management services and they were familiar with the assisted living regulations. The licensee's Application for Assisted Living License signed on August 8, 2024, section titled Official Verification of Owner or Authorized Agent, (page five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	{0 250}		

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{0 250}	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	{0 250}		

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{0 250}	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner (O)-J on August 8, 2024. An Assisted Living License was granted to licensee effective December 1, 2024, with an expiration date of November 30, 2025. As a result of this survey, the following orders were issued: 0340, 0680, 0720, 1060, 1610, 1620, 1640, 1650, 1730, 1760, 1820, 1880, 1960, 1970, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of	0 340		

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0 340	Continued From page 6 noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation taken to comply with the correction orders from a survey completed November 26, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	0 340		

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0 340	Continued From page 7 The findings include: On September 10, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A provided licensee's plan of correction (POC) at the request of the surveyor. LALD-A stated the document was the entirety of licensee's POC developed. The undated POC included the licensee's documented plan related to four (4) of the twenty-two (22) total citations issued during their previous survey exited on November 26, 2024. The citations addressed were 0470, 0480, 0650, and 0780. The licensee's POC lacked documentation of actions taken by licensee to correct citations 0250, 0680, 0720, 0780, 0790, 0800, 0810, 0830, 1060, 1370, 1380, 1470, 1620, 1640, 1760, 1880, 1910, 1940, and 1960. As a result of the licensee's lack of a developed written POC with actions licensee would take to correct citations, the following citations were reissued: 720, 1060, 1620, 1640, 1760, 1880, 1940, and 1960. Additionally, the following citations were identified and issued during the survey: 1650, 1730, 1820, 1970, and 2310. Citations 0480, 0790, 0800, 0810, and 0830 were not reviewed during the follow-up survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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 8 (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, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 9 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:	{0 480}	Not reviewed during this survey.	
{0 720} SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized representative. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 720}		

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{0 720}	Continued From page 10 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1, R2, R3, R6, and R14 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for the identified residents. The sSurveyor requested licensed assisted living director (LALD)-A to have requested documents ready for review the following day and LALD-A stated the documents would be ready. On September 11, 2025, at 9:00 a.m., surveyor arrived at the facility and requested the documents LALD-A was to have ready. LALD-A stated the documents were still being collected to provide. On September 11, 2025, at 9:55 a.m., LALD-A provided some of the requested documents for the residents, but some requested items remained missing. On September 11, 2025, at 1:00 p.m., the surveyor again requested the documents not yet provided. LALD-A stated the missing resident items would be emailed to the surveyor as some documents were not accessible in the facility at	{0 720}		

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{0 720}	Continued From page 11 that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but some requested items were not included as requested. On September 12, 2025, at 10:00 a.m., an exit conference was conducted with LALD-A to indicate the conclusion of the survey. During the exit conference, LALD-A stated the licensee was not clear on requested items even when the surveyor requested items multiple times. The survey concluded and multiple items were not provided or not readily available upon multiple requests of the surveyor. No further information was provided.	{0 720}		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 12 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based in interview and record review, the licensee failed to maintain a current resident record with all required content for one of two residents (R14). 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	0 730		

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0 730	Continued From page 13 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: R14 was admitted on June 25, 2024. R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, and activities of daily living. R14's [licensee] Nurse Reassessment Note and [licensee] Post-Hospital Current Assessment both dated August 29, 2025, indicated R14 had medication changes from a recent hospital stay. On September 10, 2025, at 11:30 a.m., the surveyor requested R14's current signed prescriber's orders. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R14. The surveyor informed LALD-A to have requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but signed provider orders for R14 were not provided. On September 11, 2025, at 1:00 p.m., LALD-A stated R14's missing provider orders would be emailed to the surveyor as items were not	0 730		

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	24780	A. BUILDING: _____ B. WING _____	R 09/12/2025

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0 730	Continued From page 14 accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed R14's provider orders. Attached to the email was a file which included a 19-page scanned file which included signed provider orders for R14. On the top left corner of the pages was a date and time stamp which started on September 11, 2025, at 2:06 p.m. and concluded on September 11, 2025, at 2:09 p.m. and the words, "HP Fax," were present after the date and time on each page. On September 12, 2025, at 10:00 a.m., LALD-A stated the licensee had called R14's pharmacy and had the pharmacy fax all R14's orders to the licensee. LALD-A stated the licensee had obtained the orders after the surveyor had requested the provider orders. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the licensee would obtain written orders for all resident medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
{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	{0 790}		

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{0 790}	Continued From page 15 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:	{0 790}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	{0 810}		

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{0 810}	Continued From page 16 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing	{0 830}		

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{0 830}	Continued From page 17 regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by:	{0 830}	Not reviewed during this survey.	
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	{01060}		

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{01060}	Continued From page 18 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to provide the notice to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return within four days for one of one resident (R14) who had an emergency relocation. 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: R14 was admitted on June 25, 2024.	{01060}		

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{01060}	Continued From page 19 R14's [licensee] RN (registered nurse) Progress Note dated August 29, 2025, indicated R14 had an emergency relocation for anxiety and shortness of breath resulting in an admission to a local hospital on August 13, 2025, and was readmitted to the licensee on August 21, 2025. R14's emergency relocation lasted a total of eight (8) days. R14's record lacked evidence of an emergency relocation notice was provided to R14, or R14's representative, and no evidence the notice was provided to the OOLTC when R14 did not return after four (4) days. On September 11, 2025, at 10:40 a.m., license assisted living director (LALD)-A stated the licensee had not provided an emergency relocation notice to R14 and had not sent the notice to the OOLTC when R14 did not return within four days. LALD-A stated the licensee was not aware of the content of an emergency relocation notice until recently when the licensee attended a training by a provider advocacy group. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, accurately indicated under the Emergency Relocation section all required content for an emergency relocation and that licensee would provide the notice to the resident and the OOLTC if the resident did not return within four days. No further information was provided.	{01060}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 20 (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 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	{01620}		

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{01620}	Continued From page 21 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1) and failed to conduct a nursing assessment by a RN of the physical and cognitive needs to include all parts of the uniform assessment tool (Minnesota Rule 4659.0150) for two of two residents (R1, R14). 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: R1 R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update authenticated August 1, 2025, indicated R1	{01620}		

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{01620}	Continued From page 22 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, activities of daily living, and supervision with community visits. On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records for requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have the requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but some of R1's items remained missing. On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing items would be email to surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but no records for R1 were provided as requested. R1's record lacked a current assessment completed by a RN with all required content per Minnesota Rule 4659.0150 within the last 90 days. R14 R14 was admitted on June 25, 2024. R14's [licensee] Nurse Reassessment Note and	{01620}		

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{01620}	Continued From page 23 [licensee] Post-Hospital Current Assessment both dated August 29, 2025, were identified by LALD-A, who was also the RN who completed the assessments, as R14's most recent comprehensive assessments. The assessments were both approximately one and one quarter (1.25) pages in length and lacked some or all of the following content required per Minnesota Rule 4659.0150: - Resident's personal lifestyle preferences; - Activities of daily living; - Instrumental activities of daily living; - Physical health status; - Emotional and mental health conditions; - Cognition; - Communication and sensory capabilities; - Pain; - Risk indicators; - Who has decision-making authority; and - Needs for follow-up referrals. On September 11, 2025, at 11:50 a.m., LALD-A stated the licensee believed assessments included all required content and no additional content was assessed for any residents. LALD-A stated the assessment template was used for all assessments the licensee conducted on residents and would all have similar content. On September 12, 2025, at 10:00 a.m., an exit conference was conducted with LALD-A to indicate the end of the survey. During the exit conference, LALD-A stated the licensee was not clear on requested items even when the surveyor requested items multiple times. The survey concluded and R1's most recent assessment was not provided or not readily available upon multiple requests of the surveyor. The licensee's Assessment and Reassessment	{01620}		

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{01620}	Continued From page 24 policy dated August 1, 2021, indicated each resident would have assessments completed no longer than 90 days from the date of the previous assessment. Additionally, the licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, referenced Minnesota Rule 4659.0150 and included identification of the required content each assessment would have included. No further information was provided..	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	{01640}		

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{01640}	Continued From page 25 by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and by the resident or resident's representative to document agreement of services to be provided for two of two residents (R1, R14). 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: R1 R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update dated August 1, 2025, indicated R1 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, activities of daily living, and supervision with community visits, but lacked authentication by the resident or resident's representative to agree upon services. The service plan included a signature line for the licensee but lacked an area for the resident or resident's representative to authenticate the service plan. R14 R14 was admitted on June 25, 2024.	{01640}		

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{01640}	Continued From page 26 R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, and activities of daily living, but lacked authentication by the resident or resident's representative to agree upon services. The service plan included a signature line for the licensee but lacked an area for the resident or resident's representative to authenticate the service plan. On September 11, 2025, at 10:40 a.m., licensed assisted living director (LALD)-A stated the licensee had used a different template for service plans in the past, but had recently transitioned to another template for residents and those service plans lacked an area for the resident or resident's representative to authenticate. LALD-A was able to provide an older service plan for R14 which included an area for authentication for the resident, but the current template the licensee was using did not have the same area. LALD-A stated a service plan with an area for the residents to authenticate would be created and each resident's signatures obtained. The licensee's Service Plan policy dated August 1, 2021, indicated all service plans and revisions to the service plans would be authenticated by the resident or the resident's representative to document agreement for services to be provided. No further information was provided.	{01640}		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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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
01650	Continued From page 27 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plans included all required content for two of two residents (R1, R14). 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	01650		

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	24780	A. BUILDING: _____ B. WING _____	R 09/12/2025

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AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

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01650	Continued From page 28 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: R1 R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update dated August 1, 2025, indicated R1 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, activities of daily living, and supervision with community visits. R14 R14 was admitted on June 25, 2024. R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, and activities of daily living. Both R1 and R14's current service plans lacked the following required content: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 29 - a contingency plan with required content. On September 11, 2025, at 10:40 a.m., licensed assisted living director (LALD)-A stated the licensee had used a different template for service plans in the past, but had recently transitioned to another template for residents and those service plans lacked the identified required content. LALD-A was able to provide an older service plan for R14 which included the required content which the current service plans lacked. LALD-A stated a service plan with the missing required content would be created for each resident. The licensee's Service Plan policy dated August 1, 2021, indicated all service plans and revisions to the service plans would include all required content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
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	01730		

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01730	Continued From page 30 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of two residents (R1). This practice resulted in a level two violation (a	01730		

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01730	Continued From page 31 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: R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update authenticated August 1, 2025, indicated R1 required services provided by the licensee which included medication management and read, "all medications and treatments must be administered and documented per MAR (medication administration record)." R1's Nursing Progress Note dated August 1, 2025, indicated R1 had a medication added to their medication management program. On September 10, 2025, at 11:30 a.m., the surveyor provided a list of requested items to review for R1 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records for requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but some of R1's items remained missing.	01730		

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01730	Continued From page 32 On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing items would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to surveyor, but no records for R1 were provided as requested. R1's record lacked a completed individualized medication management record with all required content. On September 12, 2025, at 10:00 a.m., LALD-A stated the licensee was confused about items requested although the licensee had provided requested items for another resident. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated licensee would develop a written medication management plan with all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	{01760}		

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{01760}	Continued From page 33 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication administration in residents' records for two of two residents (R1, R14). 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: R1 R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update dated August 1, 2025, indicated R1 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, activities of daily living, and supervision with community visits. On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1 related to	{01760}		

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{01760}	Continued From page 34 citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have the requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but some of R1's items remained missing. On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing items would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but no records for R1 were provided as requested. During the survey, R1's medication administration record (MAR) was not provided upon request of the surveyor. R14 R14 was admitted on June 25, 2024, with diagnosis which included schizophrenia, gastro-esophageal reflux disease, prediabetes, and hyperlipidemia. R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, and activities of daily living.	{01760}		

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{01760}	Continued From page 35 DOCUMENTATION ERRORS R14's Refill E-Script Approval dated June 26, 2025, read, "Fluphenazine HCL [hydrochloride] 10 mg [milligrams] Tabs take 1 [one] tablet by mouth 2 [two] times per day." Fluphenazine is an antipsychotic medication used primarily to treat schizophrenia. R14's MAR dated September 1, 2025, to September 10, 2025, included an order for fluphenazine HCL 10 mg tabs, take 1 tablet by mouth 2 times per day. On September 5, 2025, for the 7:30 p.m. dose, no evidence R14 received, declined, or other situations occurred to prevent R14 from receiving the prescribed medication. No documentation of actions taken when a problem arose to prevent R14 from receiving the dose was present. R14's MAR dated September 1, 2025, to September 10, 2025, included an order for prednisone 20 mg tabs (a corticosteroid) which was ordered as a taper (slowly decrease a dose until a specific end date) which was to end on September 1, 2025, with the 7:30 a.m. dose. No documentation or evidence R14 received, declined, or other situations occurred to prevent R14 from receiving the prescribed medication for the dose was present on the MAR. TRANSCRIPTION ERROR R14's Refill E-Script Approval dated August 4, 2025, included an order which read, "Hydroxyzine HCL 10 mg tabs. Take 1-2 tablets by mouth every day as needed for anxiety [illegible] Take 2 tablets as needed for sleep." R14's MAR dated September 1, 2025, to September 10, 2025, included an order which read, "Hydroxyzine HCL 10 mg tabs. Take 2	{01760}		

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{01760}	Continued From page 36 tablets as needed for sleep." R14's MAR lacked an order for the use of hydroxyzine HCL related to R14's anxiety resulting in a transcription error and R14's inability to be administered an ordered anti-anxiety medication based on MAR indications. On September 12, 2025, at 10:00 a.m., LALD-A stated all medication administration should be documented in each resident record. LALD-A stated they were not sure why staff did not document the administration or if the resident chose to not take their medications on the identified days and times. The licensee's Staff Competency policy dated August 1, 2021, indicated all staff who provide services had been trained on the appropriate documentation of services provided. No further information was provided.	{01760}		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R1).	01820		

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01820	Continued From page 37 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: R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update authenticated August 1, 2025, indicated R1 required services provided by the licensee which included medication management and read, "all staff must follow all doctor's orders as prescribed." R1's Nursing Progress Note dated August 1, 2025, indicated R1 had a medication added to their medication management program. On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have the requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but some of R1's items remained missing.	01820		

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01820	Continued From page 38 On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing items would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but no records for R1 were provided as requested. R1's record lacked evidence of written provider's orders. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the licensee would obtain written orders for all resident medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
{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 store all prescription medications according to the manufacturer's directions. The deficient practice had the potential to affect all residents.	{01880}		

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{01880}	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 11, 2025, at 11:20 a.m., the surveyor toured the licensee's medication storage room with licensed assisted living director (LALD)-A. In the secured medication room, a small cube refrigerator was noted. LALD-A was asked to open the refrigerator. Inside of the refrigerator was unopened injectable medications for R14. The surveyor requested the temperature log for the refrigerator to ensure safe storage of the medications. LALD-A stated temperatures were documented within the licensee's computer system. R14 was admitted on June 25, 2024, with diagnoses which included schizophrenia, gastro-esophageal reflux disease, prediabetes, and hyperlipidemia. R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included medication management, treatment management, meals, mental health monitoring, and activities of daily living. R14's New E-Script Prescription dated August 25, 2025, included the following order, "Mounjaro 2.5 mg [milligram]/0.5 ml [milliliter] subcutaneous pen	{01880}		

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{01880}	Continued From page 40 injector." R14's medication administration record (MAR) dated September 1, 2025, to September 10, 2025, included an order for Mounjaro to be administered weekly at 7:30 p.m. R14's MAR indicated the medication was administered on September 5, 2025, at 7:30 p.m. On September 11, 2025, at 1:00 p.m., LALD-A stated the temperature log would be emailed to the surveyor as it was not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but a temperature log for the licensee's medication refrigerator was not provided as requested. During the survey, a refrigerator temperature log was not provided upon request of the surveyor. On September 11, 2025, at 11:50 a.m., LALD-A stated all medication were stored securely and as the manufacture recommended. The Mounjaro instructions last revised June 2025, indicated unopened medication should be stored in the refrigerator between 36°F (Fahrenheit) to 46°F and if frozen should be discarded and not used. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all refrigerated medications would be maintained at 35-40°. The policy lacked identification of Fahrenheit or Celsius and lacked identification if the licensee would document temperature to ensure safe storage.	{01880}		

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{01880}	Continued From page 41 No further information was provided.	{01880}		
{01960} SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident specific documentation of the administration of a provided treatment was completed for two of two residents (R1, R14) receiving treatments. 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: R1 R1 was admitted on January 30, 2024.	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	R 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01960}	Continued From page 42 R1's [licensee] Service Plan Update dated August 1, 2025, read, "Treatment: Terbinafine HCL [hydrochloride] 1% [one percent] cream - apply to affected area at 7:30 p.m., three times weekly for six [6] weeks, then one weekly every other week." R1's Topical Treatment Plan & Procedure dated August 1, 2025, indicated staff would verify the orders on R1's MAR (medication administration record) and would document administration of the treatment on the MAR. On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have the requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but some of R1's items remained missing. On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing items would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but no records for R1 were provided as requested. During the survey, R1's MAR was not provided upon request of the surveyor.	{01960}		

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{01960}	Continued From page 43 R14 R14 was admitted on June 25, 2024. R14's [licensee] Individualized Service Plan dated August 29, 2025, indicated R14 required services provided by the licensee which included treatment management related to continuous oxygen (O2) therapy via nasal cannula. R14's undated Oxygen Therapy Treatment Plan & Quick Guide indicated staff would replace the nasal cannula every 7 days, replace the long tubing every 30 days, check R14's SpO2 (amount of O2 in a person's system) once per shift (morning, evening, and night), and document flow rate, device used, tubing checks, and SpO2 readings. R14's MAR and Service Delivery Record for September 2025, lacked any evidence of the identified required documentation from R14's treatment plan. On September 12, 2025, at 10:00 a.m., during the exit conference, LALD-A stated the licensee was not clear on the request for items the surveyor provided. LALD-A stated the licensee used another method of documentation for the identified content for the treatment plans but did not provide them upon request during the survey. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated all treatments and documentation related to treatments would be maintained in each resident's record. No further information was provided.	{01960}		

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01970	Continued From page 44	01970		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for two of two residents (R1, R14). 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: R1 R1 was admitted on January 30, 2024. R1's [licensee] Service Plan Update dated August 1, 2025, read, "Treatment: Terbinafine HCL [hydrochloride] 1% [one percent] cream - apply to	01970		

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01970	Continued From page 45 affected area at 7:30 p.m., three times weekly for six [6] weeks, then one weekly every other week." R1's Topical Treatment Plan & Procedure dated August 1, 2025, indicated staff would verify the orders on R1's MAR (medication administration record) and would document administration of the treatment on the MAR. R1's Nursing Progress Note dated August 1, 2025, read, "Terbinafine HCL 1% cream was initiated as of 8/1/25, with orders to apply three times weekly for six weeks, then once weekly every other week." On September 10, 2025, at 11:30 a.m., the surveyor provided a list of items for R1 related to citations issued from the licensee's previous survey. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R1. The surveyor informed licensed assisted living director (LALD)-A to have requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but signed provider orders for R1's treatment was not included. On September 11, 2025, at 1:00 p.m., LALD-A stated R1's missing provider treatment orders would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed documents to the surveyor, but no records for R1 were provided as requested.	01970		

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01970	Continued From page 46 R1's record lacked evidence of written provider's orders. R14 R14 was admitted on June 25, 2024. R14's [licensee] Individualized Service Plan dated August 29, 2025, read "continue oxygen therapy 2 [two] liters via nasal cannula as prescribed." R14's [licensee] Nurse Reassessment Note and [licensee] Post-Hospital Current Assessment both dated August 29, 2025, indicated R14 required oxygen treatment. On September 10, 2025, at 11:30 a.m., the surveyor requested R14's current signed prescriber's treatment orders. On September 10, 2025, at 1:30 p.m., the surveyor left the facility, and the licensee had not provided any records requested for R14. The surveyor informed LALD-A to have the requested documents ready for review the following day. On September 11, 2025, at 9:55 a.m., LALD-A provided a stack of documents for residents, but signed provider orders for R14 were not provided. On September 11, 2025, at 1:00 p.m., LALD-A stated R14's missing provider orders would be emailed to the surveyor as items were not accessible in the facility at that time. On September 11, 2025, at 7:53 p.m., the licensee emailed R14's provider orders. Attached to the email was a file which included a 19-page scanned file which included signed provider orders for R14. On the top left corner of the	01970		

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01970	Continued From page 47 pages was a date and time stamp which started on September 11, 2025, at 2:06 p.m. and concluded on September 11, 2025, at 2:09 p.m. and the words, "HP Fax," were present. No order for oxygen treatment was included. On September 12, 2025, at 10:00 a.m., LALD-A stated the licensee had used both R1 and R14's after visit summary (an unsigned document provided with a synopsis of a resident's visit with a provide) as orders to develop a treatment plan for each resident. LALD-A stated signed provider orders were not obtained for R1 and R14's treatments. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated licensee would obtain written orders for all resident medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care	02310	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope	

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02310	Continued From page 48 standards, medical or nursing standards for one of one resident (R14) who utilized hospital style bed rails. 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: On September 10, 2025, at 10:00 a.m., during a tour of resident bedrooms, the surveyor noted R14 had bilateral hospital style bed rails in place. R14's bed was positioned against the wall so R14 could only exit on the right side of the bed as a person looked at R14's bed. The bed rail on the right side of R14's bed was in the down position allowing R14 to freely exit, while the bed rail on the left side (against the wall) was in the raised position allowing R14 to use for bed mobility. On September 11, 2025, at 10:10 a.m., surveyor requested licensed assisted living director (LALD)-A (who was also the licensee's clinical nurse supervisor/registered nurse) tour R14's bedroom to review the bed rails. Upon entering R14's room, the bed rails on the right side of the bed had been removed from the bed while the left side bed rails remained as noted on the previous day. R14 was admitted on June 25, 2024. R14's Individualized Service Plan dated August 29, 2025, lacked identification R14 required bed	02310	and level remain unchanged.	

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02310	Continued From page 49 rails or the management of bed rails services under the ADLs (activities of daily living) & Physical Support section of the service plan. R14's Post-Hospital Current Assessment dated August 29, 2025, lacked assessment of R14's need for bed rails and the required content to address safety related to R14's use of bed rails. R14's Nurse Reassessment Note dated August 29, 2025, indicated R14 had an unsteady gait (walking) and ambulated (method of a person's walking) with staff support, but lacked assessment of R14's need for bed rails and the required content to address safety related to R14's use of bed rails. R14's RN (registered nurse) Progress Note dated August 29, 2025, read, "Resident ambulates with unsteady gait and requires close supervision. Reports intermittent anxiety and auditory hallucinations but responds to redirection and calm environment." R14's record lacked any assessment, documentation, or required content for bed rails to ensure R14's safe use of bed rails. Additionally, the assessments lacked addressing R14's needs for safe transfers with or without bedrails. On September 11, 2025, at 10:10 a.m., LALD-A stated R14's right side bed rail was removed the previous day after the surveyor noted them during a tour. LALD-A stated the bed rails were on the bed when R14 moved into the facility. LALD-A stated R14's provider was made aware of the bed rails, but no order was obtained as LALD-A believed R14 did not use the bed rails. LALD-A stated no bed rail measurements were taken, or	02310		

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02310	Continued From page 50 assessment was conducted on R14's ability to safely use the bed rails. The licensee's Side Rail Use policy dated August 1, 2021, indicated all residents who utilize bed rails would have an assessment conducted every 90 days to address the safe use of the bed rails, purpose of the bed rails, education provided to the resident and/or the resident's representative, and the bed rails were installed and maintained according to the manufacturer's recommendations. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Additionally, the FAQ indicated the nurse must abide by accepted health care standards, and the use of portable bed rails according to manufacturer's guidelines is one of those accepted standards. Documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail; - measurements; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment;	02310		

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02310	Continued From page 51 - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. In addition, the MDH FAQ indicated licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Food and Drug Administration's (FDA), A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006 indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Electronically Delivered

March 18, 2025

Licensee
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429

RE: Project Number(s) SL24780016-0, HL247806520C, HL247808703C/HL247806061M and HL247809430C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey and complaint investigation (HL247809430C) on November 26, 2024, for the purpose of investigating and assessing compliance with state licensing statutes.

In addition, complaint investigations (HL247806520C and HL247808703C/HL247806061M) were completed on October 25, 2024, including an instance of substantiated maltreatment and are being considered in our determination under this enforcement action.

MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $3,000.00

Additionally, the licensee was determined to be responsible for the following instance of substantiated maltreatment, thus, the following fines will be imposed against your license:

R1 - HL247806061M - Substantiated Maltreatment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $7,000.00**. 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.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Amazing Love Assisted Living. Please contact Jess Schoenecker at 651-201-3789 on or before **Friday, March 21, 2025,** to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

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0 000	Initial Comments An immediate correction order was identified on November 20, 2024, issued for SL24780016-0, tag identification 0780. 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: SL24780016-0 On November 18, 2024, through November 26, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 resident(s); 12 receiving services under the Assisted Living Facility license. The Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued related to HL247809430C, tag identification 470 and 1620. On November 20, 2024, an immediate correction order was issued for tag identification 0780.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on November 18, 2024, at 10:30 a.m., licensed assisted living	0 250		

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0 250	Continued From page 3 director (LALD)-A stated the licensee provided medication and treatment management services and they were familiar with the assisted living regulations. The licensee's Application for Assisted Living License signed on August 8, 2024, section titled Official Verification of Owner or Authorized Agent, (page five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner (O)-J on August 8, 2024. An Assisted Living License was granted to licensee effective December 1, 2024, with an expiration date of November 30, 2025. As a result of this survey, the following orders were issued: 0470, 0480, 0650, 0680, 0720, 0780, 0790, 0800, 0810, 0830, 1060, 1370, 1380, 1470, 1620, 1640, 1760, 1880, 1910, 1940, and 1960, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 6 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure their staffing plan was sufficient to meet the scheduled needs and reasonably foreseeable unscheduled needs of their resident population when the licensee provided care and services to thirteen residents who had significant mental health diagnoses and negative behaviors including substance abuse, physical aggression, stealing, property destruction, and suicidal ideation. This deficient practice had the potential to cause serious harm to all residents.	0 470		

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0 470	Continued From page 7 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RESIDENT NEEDS On November 18, 2024, at 7:44 a.m., the surveyor sent an email to the licensee to inform them of the surveyor would arrive to conduct the assisted living survey. The surveyor requested the licensee's resident roster. The licensee's undated resident roster indicated there were twelve residents receiving care and services by the licensee, but one resident was at the hospital. The roster also indicated: -thirteen residents required psychotropic medications (drugs that effect mind, emotions, behaviors); -two resident required insulin and blood glucose monitoring; -one resident required dialysis; -one resident required wound care; and -one resident required physical therapy. R1 R1 admitted to the licensee on January 30, 2024. R1's diagnoses included schizophrenia and psychotic disorder. R1's diagnoses included a history of methamphetamine abuse, sexual misconduct, and domestic assault via strangulation.	0 470		

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0 470	Continued From page 8 R1's care plan dated November 18, 2024, indicated he had a "Jarvis" order (court issued petition that mandates a resident receive antipsychotic medication without their consent) and required medication administration. The care plan indicated R1 also had a "Price Sheppard" (court ordered electroshock therapy (ECT) administered without the resident's consent) and received ECT. The care plan indicated R1 had a poor attention span and poor judgement. The care plan indicated R1 angered easily and was "uncontrollable" and resistive to redirection. The care plan indicated R1 violated sexual boundaries when he was anxious. The care plan indicated R1 was "uncontrollable" when physically aggressive and would damage property. The care plan indicated R1 had a history of smoking in his room. The care plan indicated R1 "lashed out" at others for no reason when he was psychotic. The care plan indicated R1 had a history of consumption of "meth" and other polysubstance drugs. The care plan indicated R1 was easily manipulated, persuaded, and exploited when out in the community to carry out "illegal acts". The care plan indicated staff members were to ensure R1 documented his whereabouts when out in the community. R2 R2 admitted to the licensee on January 26, 2024. R2's diagnoses included generalized anxiety disorder, major neurocognitive disorder, depressive disorder, hypertension, insulin dependent diabetes mellitus (IDDM), chronic obstructive pulmonary disease (COPD), kidney disease, alcoholism, coronary artery disease, pacemaker, and stent. R2's care plan dated September 27, 2024,	0 470		

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0 470	Continued From page 9 indicated R2 required mobility assistance from staff for all cases and mobility because he had a closed right ankle fracture and acute traumatic pain. The care plan indicated R2 was non-weight bearing on his right leg. R3 R3 admitted to the licensee on January 31, 2024, and discharged from the licensee on September 24, 2024. R3's diagnoses included schizophrenia and cluster B personality disorder. R3's diagnoses included a history of alcohol and marijuana use. R3's care plan, no date, indicated he had a "Jarvis" order from the court and required medication administration. The care plan indicated R3 had a poor attention span and poor judgement. The care plan indicated R3 smoked inside the home and was verbally aggressive with redirection. The care plan indicated R3 angered easily and was "uncontrollable" and resistive to re-direction. The care plan indicated R3 had anxiety and when he was anxious, he violated sexual boundaries. The care plan indicated R3 had physical aggression and would "lash out" at others for no reason and staff were required to keep objects that could cause harm away from him. The care plan indicated R3 used "meth" and other polysubstance drugs. The care plan indicated R3 was antisocial, narcissistic, and impulsive. The care plan indicated staff members needed to ensure to document R3's "whereabouts" when out in the community because he was easily manipulated, persuaded, and exploited to carry out improper and illegal acts. The care plan indicated staff members need to remind R3 he was not allowed at Holiday gas station because he shoplifted from them.	0 470		

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0 470	Continued From page 10 R4 R4 admitted to the licensee on April 12, 2023, for diagnoses including schizoaffective disorder, alcohol use disorder (severe), cocaine use disorder, and anxiety disorder. R4's care plan dated September 12, 2024, indicated she was on "civil commitment". The care plan indicated staff members needed to complete "rounds" every two hours and monitor R4 for anxiety, isolation, verbal aggression, and agitations. R5 R5 admitted to the licensee on March 3, 2023, for diagnoses including anxiety, left-sided weakness, muscle disorder, and Wolf-Parkinson-White (WPW) disease (rapid hear beat). R5's care plan dated September 25, 2024, indicated R5 required two staff "or more" staff members to safely transfer him out of bed. The care plan indicated R5 used a wheelchair and had a "deep-rooted" fear of falling. The care plan indicated R5 required total staff assistance for toileting and bathing cares. The care plan indicated R5 had a brain injury and had short-term memory loss. R6 R6 admitted to the licensee on April 12, 2023, for diagnoses including schizophrenia, catatonic schizophrenia, psychosis, anxiety, depression, and marijuana use. R6's care plan dated September 14, 2024, indicated staff members needed to monitor him for stealing, property destruction, verbal aggression and wandering. The care plan indicated R6 had a history of stealing from stores	0 470		

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0 470	Continued From page 11 and the nearby gas station. The care plan indicated R6 had a history of using other resident's credit/debit cards. The care plan indicated R6 was "very confrontational". The care plan indicated R6 was a "fire hazard" because he liked to smoke in his room and would hide in his closet when he smoked. The care plan indicated R6 had a history of setting the room on fire. R7 R7 admitted to the licensee on July 24, 2024, for diagnoses including delusional disorder, anxiety, mild neurocognitive impairment, paranoia, sexual misconduct, grandiosity, auditory hallucinations, and diabetes. R7's care plan dated September 26, 2024, indicated R7 had periods of disorientation and mild cognitive impairment. The care plan indicated R7 had a poor attention span and poor judgement. The care plan indicated R7 had paranoia and delusions. The care plan indicated staff members were to monitor R7 for inappropriate sexual behavior, soliciting, and disorderly conduct. R8 R8 admitted to the licensee on July 8, 2024, for diagnoses including end stage renal (kidney) disease, dialysis dependent, hemiplegia, right leg amputation, mood disorder, diabetes, depression, ineffective coping, and suicidal ideation. R8's care plan dated September 2, 2024, indicated R8 had physical mobility limitations due to amputation of his right leg. The care plan indicated R8 required dialysis three times weekly. The care plan indicated R8 had poor judgement and a decline in his cognition. The care plan indicated R8 suffered from post-traumatic stress	0 470		

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0 470	Continued From page 12 disorder (PTSD) and had a history of suicide ideation. The care plan indicated R8 was easily agitated and "uncontrollable" and resistive to re-direction. R9 R9 admitted to the licensee on July 14, 2017, for diagnoses including chronic undifferentiated schizophrenia, paranoid schizophrenia, psychosis, and psychotic disorder. R9's care plan dated September 14, 2024, indicated R9 was verbally aggressive and had disruptive behaviors. The care plan indicated R9 had sexually inappropriate behaviors. The care plan indicated R9 required 1 to 1 staff member support. R10 R10 admitted to the licensee on September 24, 2024, for diagnoses including schizophrenia and paranoid delusions. R10's care dated September 24, 2024, indicated he was uncontrollable when he was agitated. The care plan indicated R10's behavior was impulsive and unpredictable. The care plan indicated R10 was quick to anger and required staff members to keep potentially harmful objects away from him. The care plan indicated R10 would hit or punch others when he is paranoid and required staff to call law enforcement when he was out of control. The care plan indicated R10 required staff members to monitor him for alcohol and other chemical substance use. R11 R11 admitted to the licensee on April 6, 2023, for diagnoses including schizoaffective disorder, bipolar type, and violent tendency.	0 470		

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0 470	Continued From page 13 R11's care plan dated September 14, 2024, indicated R11 had poor impulse control when he was anxious. The care plan indicated R11 was uncontrollable when he was physically aggressive and damaged property. The care plan indicated R11 was physically aggressive and would "lash" out at others for no reason. The care plan indicated R11 required staff members to keep harmful objects away from him. The care plan indicated R11 had a history of polysubstance drug use including cocaine, meth, cannabis, crack/cocaine. The care plan lacked duration and frequency for staff members to monitor him for safety. R12 R12 admitted to the licensee on April 9, 2024, paranoid schizophrenia, psychosis, history of suicidal attempt, and a history of phenylcyclohexyl piperidine (PCP) and amphetamine/stimulant abuse. R12's care plan dated September 14, 2024, indicated R12 had a history of strangling staff. The care plan indicated staff members should believe R12 if he threatened to do so. The care plan indicated staff members should monitor for verbal aggression/disruption to others, anxiety, agitation, suicidal ideation, and physical aggression. The care plan indicated R12 required 8 hours of 1 to 1 activity (4 hours in the morning and early afternoon, and 4 hours in the afternoon/evening). Multiple areas in the care plan indicated R12 required 1 to 1 staff interaction. R13 R13 admitted to the licensee on March 15, 2019, and discharged from the licensee on November	0 470		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 470	Continued From page 14 8, 2024. R13's diagnoses included schizoaffective bipolar type disorder. R13's care plan dated October 3, 2024, indicated staff were to monitor R13 for self-injurious behavior and report any comments about suicide or suicidal ideation. The care plan indicated staff should contact a nurse if they observe any cuts, scratched, or skin changes. The care plan indicated R13 had hallucinations and delusions and had a history of elopements. The care plan indicated staff were to monitor R13 for substance abuse and R13 had a history of using cocaine, meth, and cannabis. The care plan indicated R13 engaged in dangerous behaviors to obtain drugs. The care plan indicated staff members were to monitor R13 for paranoia, wandering, anxiety, property damage, public urination, and agitation. The care plan indicated R13 required 1 to 1 staff interaction at times. The care plan indicated staff were to do "rounds" every one to two hours. RESPONSE TO RESIDENT EMERGENCIES R1 R1's incident reports completed by the licensee indicated: - September 11, 2024, no time, indicated staff found R1 smoking in his room and observed a piece of aluminum foil with black smoke residue on the back of his nightstand. The report indicated R1 said, "It was nothing", then took the foil downstairs. The report indicated later in the day, R1's sister told staff he took money from her purse. The report indicated staff notified the care team, primary physician, and "psych" physician by fax. The house manager (signature not legible) signed the incident report on September 13, 2024. - September 11, 2024, no time, indicated "another resident" told staff two months prior R1 said he	0 470		

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0 470	Continued From page 15 liked the resident (male/female not indicated) and wanted to have a relationship. The resident agreed and said, "we ended up having sex, but he almost raped me to death". The incident report failed to identify which resident reported this incident. The incident report indicated all protocols were followed and the "LAD" called (name unidentified) and left a voice message. The house manager (signature not legible) singed the incident report on September 17, 2024. - September 18, 2024, no time, indicated staff observed a piece of aluminum foil with black smoke residue on the back of it, with a cut-up bule straw that was melted at the tip on R1's nightstand. The report indicated staff removed the foil and straw. The report further indicated later in the day, R1 locked himself in another resident's room, and when he opened the door, staff observed another piece of foil in his hand with nothing in it. The incident report indicated the care team was notified. The house manager (signature not legible) signed the incident report on September 18, 2024. R1's progress notes indicated: -October 24, 2024, at 6:23 a.m., indicated a staff member found R1 smoking in his room. -October 24, 2024, at 4:07 p.m., indicated a staff member found R1 smoking in his room. -October 26, 2024, at 6:30 p.m., indicated a staff member found R1 smoking in his room. -November 2, 2024, at 8:10 a.m., indicated a staff member found R1 smoking "meth" in his room. The progress note indicated a staff member completed safety checks every two hours. R3 R3's incident reports completed by the licensee indicated on: -September 10, 2024, at 12:35 a.m., indicated a	0 470		

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0 470	Continued From page 16 staff member told R3 to turn the television volume done and he threatened to "smack" a staff member. The report indicated R3 manipulated the gas stove to light his cigarette and threatened to burn down the house along with staff members. The report indicated R3 continued to manipulate the gas stove and smoke and threatened to "smack" the staff member. The report indicated the staff member called licensed assisted living director (LALD)-A who then spoke to R3 (by phone), but R3 continued to smoke. The report indicated R3 threatened to burn the staff member with his cigarette. The report indicated LALD-A called law enforcement, but R3 left the licensee prior to their arrival. The report indicated law enforcement then returned to the licensee at 3:05 a.m., and told a staff member they found R3 and took him to jail because he assaulted law enforcement officers. R3's progress notes indicated: -August 25, 2024, at 12:04 a.m., indicated R3 was trying to fight with another resident and the other resident tried to run away and told R3 he did not want to fight. The progress notes indicated R3 kept "coming at the resident". The progress notes lack further detail about the altercation, but indicated the licensee called law enforcement. The progress notes indicated four minutes later, R3 was verbally abusive to staff, and the licensee called law enforcement and they took him to the hospital. -August 29, 2024, at 9:44 a.m., indicated R3 hit a resident on the head, hard, while the resident was sleeping on the couch. The progress notes indicated the licensee called law enforcement and they took the resident to the hospital. -September 10, 2024, at 8:35 a.m., indicated R3, "created a scene" beginning at 12:35 a.m., until about 2:50 a.m. The progress notes indicated the	0 470		

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0 470	Continued From page 17 licensee called law enforcement and they removed R3 from the home. The progress note lacked further information about R3's behavior, but indicated the licensee completed an incident report. STAFFING SCHEDULE On November 19, 2024, at 11:14 a.m., the surveyor observed the licensee's monthly staffing schedule dated November 1, 2024, through November 30, 2024. The schedule indicated the start times for the shifts varied. For example, the staffing schedule indicated: November 1: Morning shift: -one unlicensed personnel (ULP) 7:00 a.m. to 3:30 p.m. -one ULP 8:00 a.m. to 1:00 p.m. Evening shift: -two ULPs 3:00 p.m. to 11:30 p.m. Night shift: -one ULP 11:59 p.m. to 8:30 a.m. -one ULP 11:00 p.m. to 7:00 a.m. The schedule indicated there were fifteen days the licensee scheduled two ULPs for the morning shift and fifteen days the licensee scheduled three ULPs for the morning shift. The schedule indicated the licensee scheduled two ULPs for the evening and night shift. On November 19, 2024, at 1:38 p.m., the surveyor asked ULP-C to interview, however ULP-C was unavailable to interview. ULP-C said the ULP scheduled to work at 1:00 p.m., called in sick. On November 20, 2024, at 12:11 p.m., LALD-A said the staff member scheduled to work from 1:00 p.m. to 9:00 p.m., did not call-in sick yesterday (November 19, 2024). The ULP in	0 470		

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0 470	Continued From page 18 question told LALD-A one month prior she was unable to work. LALD-A said they had more than enough ULPs to meet their staffing plan. LALD-A acknowledged the staffing schedule should accurately reflect the staff members who were working. The licensee's uniform disclosure of assisted living services and amenities (UDALSA) dated August 8, 2024, indicated the licensee typically scheduled four unlicensed personnel (ULP) for the day shift, three for the evening shift, and two for the night shift. However, the UDALSA did not reflect the current staffing practices of the licensee. The licensee's undated staffing plan indicated there would be "2-3" direct care staff for the morning and evening shifts and two direct care staff working during the night shift. The staffing plan lacked evidence of evaluation of residents' needs to determine appropriate staffing levels. The staffing plan also lacked evidence it was reviewed twice a year. On November 19, 2024, at 2:30 p.m., ULP-C said the licensee was always fully staffed but the start times for the shifts vary somewhat. ULP-C said there was always a nurse at the licensee until 5:00 p.m., and after 5:00 p.m., there was a number to call. ULP-C said the nurse watched the computer and if you didn't chart something, she called the ULPs. ULP-C said there were two nurses on-call, and their numbers were "linked", so if you called, they responded immediately. ULP-C described the resident population as multi-cultural individuals who socialized amongst themselves. ULP-C said there were no residents who required mechanical lifts for transfers and only two residents who required wheelchairs for	0 470		

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0 470	Continued From page 19 mobility. ULP-C said, "once in a while" the residents could get "agitated" and when they do, the ULPs call the nurse and follow her instructions. ULP-C said there were five residents who smoked in their rooms. ULP-C said all residents receive safety checks every two hours, but they do not document the safety checks or what they observed during the safety checks. ULP-C said sometimes staff members have to call emergency services (911), but said it had been a long time ago, and nothing recently. ULP-C said she would know if other ULPs called 911 because those ULPs would tell her. ULP-C said she was unsure how she would know about resident substance abuse, but would report if the resident used substances, or if the resident acted unusual, she would report what she saw to the nurse. On November 20, 2024, at 10:33 a.m., ULP-G said there were always three staff members on the morning shift. ULP-G said the nurse was always there. ULP-G described the resident population as "quite good". ULP-G said he would call the nurse if a resident was aggressive, and the nurse would then direct him what to do. ULP-G said he called 911 by himself for one resident who was uncontrollable. ULP-G said their resident used "meth" or "something". ULP-G was unsure of the name of the resident, and when this occurred, but an incident report was completed. ULP-G said sometimes the residents fight and the licensee needed help from law enforcement. ULP-G said he completed safety checks every ten minutes or every one hour and documented them in the residents' progress notes. During the interview, the surveyor observed R1 turn on the stove and attempt to light a cigarette. Another ULP responded and assisted R1 away from the stove.	0 470		

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0 470	Continued From page 20 On November 20, 2024, at 12:11 p.m., LALD-A said the licensee "mainly" accepted residents with mental health diagnoses. The surveyor asked LALD-A if safety checks every two hours was sufficient to meet the needs for the resident population and LALD-A said the licensee's UDALSA indicated safety checks could be completed every two hours but if a resident was having a crisis, they might have to sit with them 1 to 1. LALD-A said the licensee did not want to change the UDALSA because they did not have the staff to accommodate further changes. LALD-A said the licensee called COPE (mobile crisis response) if there was a resident issue they could not handle. LALD-A acknowledged R1 smoked inside the home and said staff members needed to be diligent in their observation of him. LALD-A said R1's family members do not want him to receive 1 to 1 staff observation but did agree to hourly checks. The surveyor asked LALD-A how/if the licensee's staffing patterns keep the residents safe, but LALD-A did not acknowledge the staffing pattern, but explained how the residents' medications make a huge difference in the residents' behavior. LALD-A said if the residents do not take their medications, she makes their psychiatric physicians aware. LALD-A acknowledged the lack of documentation from ULPs regarding safety checks, but said they do document in the progress notes. LALD-A said law enforcement was only at the licensee once after R13 discharged (November 8, 2024). Law enforcement records dated June 29, 2024, through November 23, 2024, indicated law enforcement responded to the licensee fifty-three (53) times for instances such as disturbances, missing persons, sex crimes, accidents, assault, mental health problems, and a narcotic	0 470		

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0 470	Continued From page 21 complaint. On November 26, 2024, at 11:55 a.m., city office mental health coordinator (MHC)-H, said the licensee called law enforcement to enforce household rules, but law enforcement had no ability to enforce them. MHC-H said law enforcement received multiple calls for mental health crises and the licensee asked law enforcement to place residents on a "hold". MHC-C said the licensee knowingly accepted residents who the court placed on commitment, but then failed to monitor/ensure their safety. MHC-C said law enforcement received multiple calls regarding "missing" residents, however upon their arrival to the licensee, staff members failed to have looked for the residents. MHC-C said when law enforcement arrived to the licensee, the staff members appeared unaware of their residents' diagnoses or how to obtain information regarding them. MHC-H said law enforcement met with the licensee's leadership, but the leadership had been resistive in working with them. MHC-H said the licensee's written interventions for the management of the residents did not appear to be implemented from law enforcement's observations and interactions. MHC-H said since January 2024 through November 26, 2024, law enforcement received 149 calls regarding the licensee, and this was over three times the amount of calls from other licensed facilities. The licensee's Staffing policy dated August 1, 2021, indicated the licensee would develop and implement a staffing plan that ensures adequate staffing to meet the residents' needs at all times, including foreseeable needs. No further information was provided.	0 470		

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0 470	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to	0 480		

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0 480	Continued From page 23 install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	0 480		

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0 480	Continued From page 24 Beverage Establishment Inspection Report (FBEIR) dated November 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 650		

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0 650	Continued From page 25 review, the licensee failed to ensure the employee record contained the required content to include direct supervision of staff providing delegated tasks within 30 days for two of two unlicensed personnel ((ULP)-C, ULP-F) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C On November 18, 2024, at approximately 12:35 p.m., the surveyor observed ULP-C administering medications to R11 and R12. ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked documentation of a direct supervision of a delegated task by a registered nurse (RN) within 30 days of orientation. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked documentation of a direct supervision of a delegated task by a registered nurse (RN) within 30 days of orientation.	0 650		

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0 650	Continued From page 26 R2's record included a Medication Administration Record dated November 2024, indicating ULP-F had administered Humalog insulin to R2 at 7:30 a.m., on November 1, 2, 3, 4, 7, 8, 14, 15, and 18, 2024. On November 20, 2024, at 1:40 p.m., licensed assisted living director (LALD)-A stated she completed the 30-day supervision for staff members on delegated tasks. LALD-A stated she did not know why the documentation was missing from the files and she would have to look for it. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision of home health aides perfuming delegated tasks will be provided within 30 days after the individual begins working for {licensee} and thereafter as needed based on performance, and that supervision would be documented in the employee's personnel file. The licensee's Personnel Records policy dated August 1, 2024, indicated documentation of supervision, as applicable, would be kept in the employee's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 680	Continued From page 27 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 28 The findings include: On November 18, 2024, at approximately 3:45 p.m., the surveyor requested a copy of the licensee's emergency preparedness plan. On November 19, 2024, at approximately 4:00 p.m., the surveyor requested the licensee's emergency preparedness plan. Licensed assisted living director (LALD)-A stated the plan was not kept on site and that she would notify human resources to send the plan. On November 20, 2024, at approximately 2:20 p.m., the surveyor again requested the licensee's emergency preparedness plan. On November 25, 2024, at 3:32 p.m., the survey concluded without the surveyor receiving licensee's emergency preparedness plan. The licensee's Emergency Preparedness policy dated August 1, 2021, read "[Licensee] will have an identified plan in place to assure the safety and well being of residents and staff during periods of an emergency or disaster that disrupts services". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a	0 720		

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0 720	Continued From page 29 manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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: R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1 received services including management and administration of medications. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2 received services including management and administration of medications. On November 18, 2024, at 3:45 p.m., the	0 720		

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0 720	Continued From page 30 surveyor requested signed prescriber orders and medication management assessments for R1 and R2. On November 19, 2024, at approximately 10:45 a.m., and 4:00 p.m., the surveyor again requested signed prescriber orders and medication management assessments for R1 and R2. On November 19, 2024, at approximately 4:00 p.m., licensed assisted living director (LALD)-A stated she would notify clinical nurse supervisor (CNS)-B to provide the requested information. On November 20, 2024, at 2:20 p.m., the surveyor again requested signed prescriber orders and medication management assessments for R1 and R2. Although requested, the surveyor did not receive signed prescriber orders and medication management assessments for R1 and R2 prior to the completion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of	0 780		

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0 780	Continued From page 31 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 comply with the current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. 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 three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 780		

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0 780	Continued From page 32 has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. During the tour, the surveyor asked M-E and LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 2: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 3: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 4: Two windows measuring 19 1/2 inches clear width, 37 inches clear height, and 721 1/2 square inches total open area for each window. Bedroom 8: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. Bedroom 9: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. Bedroom 10: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and	0 780		

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0 780	Continued From page 33 936 square inches total open area for each window. Bedroom 11: Two windows measuring 19 1/2 inches clear width, 48 inches clear height, and 936 square inches total open area for each window. The openings in each resident bedroom were obstructed by the windowpane due to how the crank hardware and arm moved the window. In the closed position the clear widths measured over 20 inches, but when opened the clear opening widths were reduced significantly. M-E attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. The windows in bedrooms 2, 3, 4, 8, 9, 10, and 11 did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On November 20, 2024, the surveyor explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they did not realize the windows were not compliant and would get them replaced as soon as possible.	0 780		

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0 780	Continued From page 34 TIME PERIOD FOR CORRECTION: Immediate. On the same facility tour on November 20, 2024, the following was observed: SMOKE ALARMS LALD-A initiated a test of the smoke alarms throughout the two houses. Upon testing, it was found that the smoke alarms in House 1 were not interconnected in bedroom 11 and the upper level living room. Upon testing, it was found that the smoke alarms in House 2 in bedrooms 1, 2, 4, and 5 did not sound when tested. None of the smoke alarms in House 2 were interconnected. SMOKING AND CIGARETTE DISPOSAL A resident was observed attempting to light a cigarette on the gas stove in the kitchen while surveyors were conducting an interview with LALD-A in the adjacent room. A staff member stopped the resident and told him that he was not allowed to smoke inside. Resident sleeping room 5 on the main level was being used as a cigarette rolling station and had ash and burn marks on the top of the night stand adjacent to the bed. There was also a black cup on the night stand that was used as an ashtray. Resident sleeping rooms 10 and 11 on the upper level had ash and burn marks on the top the night stands adjacent to the beds. Used cigarette smoking materials are required to be discarded in appropriate containers in the designated, exterior smoking areas. There were appropriate containers provided for discarding the	0 780		

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0 780	Continued From page 35 used cigarette butts outside. On November 20, 2024, at 3:30 p.m. LALD-A stated they did not know that the smoke alarms were not fully interconnected in House 1. LALD-A also stated that House 2 was used to isolate residents who were ill with Covid-19. House 2 was currently unoccupied and LALD-A did not know the smoke alarms were not working or interconnected. LALD-A also stated they suspected some of the residents were smoking in the sleeping rooms, but never caught them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	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 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.	0 790		

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0 790	Continued From page 36 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. The portable fire extinguishers throughout the two buildings lacked records to show monthly visual inspections were completed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. The fire extinguisher in the laundry room of house 1 was 1-A:10-BC rated. All fire extinguishers in the facility must meet the minimum requirement of 2-A:10-B:C. On November 20, 2024, at 3:30 p.m., the surveyor explained to LALD-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all	0 790		

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0 790	Continued From page 37 portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A stated they did not know monthly inspections were required. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 38 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 20, 2024, from 10:30 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. At 11:00 a.m. maintenance staff (M)-E joined the tour and LALD-A left the tour. At 12:15 p.m. M-E had an appointment to get to and LALD-A rejoined the tour at 1:00 p.m. to complete the tour of building 2. HOUSE ONE: - The window hardware in bedrooms 2, 3, 4, and 5 was not maintained. The casement style windows were missing the crank or the crank interior was stripped and unable to open the winodw. M-E replaced the crank in each bedroom at the time of discovery. - The kitchen floor tiles were cracked throughout the whole kitchen. - The bathroom adjacent to the laundry room had significant cracking in the shower floor insert. It was also broken around the drain area. The window crank to the operable window was missing. - The bathroom across the hall from the laundry room was missing the window crank and the wood trim was missing from the door. HOUSE TWO: - The upper-level bathroom ceiling had water damage by window.	0 800		

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0 800	Continued From page 39 - The window in bedroom 4 was not able to close fully once it was open. The closet door was falling off the track. - The wood trim was missing at kitchen door jamb. - The lower-level bathroom had holes in the ceiling around the plumbing work. The window is open to structure above. On November 20, 2024, at 3:30 p.m., LALD-A stated they would correct the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 40 (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, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, at 2:30 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility.	0 810		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

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0 810	Continued From page 41 On November 20, 2024, at 3:30 p.m., LALD-A stated they did not have the fire safety and evacuation plan (FSEP) on site and would have a member of their human resources (HR) team email the FSEP, fire safety and evacuation training, and evacuation drills for the facility to the surveyor by noon on November 21, 2024. On November 22, 2024, the surveyor received an email with the FSEP and drill logs attached. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.	0 810		

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0 810	Continued From page 42 TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. Provided documentation included "Fire Drill Reports", dated August 26, 2022, August 23, 2022, November 02, 2022, July 31, 2024, and September 25, 2024, included a statement at the top which read, "I have been educated on how to safely evacuate this building." with signatures below the statement. The fire drill reports were dated for the same days as the licensee recorded fire drills being completed. There was no complete record provided that all staff received the required training. Training must be provided to all staff on the fire safety and evacuation plan and shall be conducted separately from fire evacuation drills. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Emergency Drill Reporting Form", indicated evacuation drills were conducted on April 10, 2023, April 28, 2023, July 6, 2023, September 28, 2023, November 4, 2023, January 6, 2024, March 6, 2024, May 2, 2024, and July 31, 2024. Emergency Drill Reporting Form lacked times or indication of shift for each documented evacuation drill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 43 (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of three residents (R1, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, during a facility tour at approximately 1:00 p.m., the surveyor observed multiple cigarettes burns on the bedside stand in bedroom #10 (belonging to R1) along with multiple cigarette butts and a cigarette lighter.	0 830		

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0 830	Continued From page 44 The surveyor noted the room smelled of cigarette smoke. The surveyor was accompanied by licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B who both stated the room smelled of cigarette smoke. LALD-A removed the cigarette lighter from the resident room and stated, "he knows he is not supposed to be doing that". LALD-A stated they were having problems with R1's family providing smoking materials to him, and a care conference had been held with the family to discuss smoking issues earlier in the day. On November 20, 2024, at approximately 10:30 a.m., the surveyor observed R1 lighting a cigarette from a gas stove in the kitchen. A staff member intervened and removed R1 from the area. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on September 7, 2023, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2024, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room	0 830		

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0 830	Continued From page 45 maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 830		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 46 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on February 1, 2024, and began receiving assisted living services. R3's Service Plan dated February 1, 2024, indicated R3's services included mealtime assistance and medication and behavioral management.	01060		

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01060	Continued From page 47 R3's record included Progress Notes that indicated R3 had been taken to the hospital on August 29, 2024, and had returned from the hospital on September 5, 2004. R3's Progress Note dated September 10, 2024, at 8:35 a.m., indicated R3 had been removed from the facility by the Crystal police department. R3's record included a Discharge Summary dated September 20, 2024. On November 19, 2024, at approximately 4:00 p.m., licensed assisted living director (LALD)-A stated they did not provide an emergency relocation notice to the resident's legal representative or notify the Office of Ombudsman for Long-Term Care when R3 was admitted to the hospital on August 29, 2024, or on September 10, 2024. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of emergency relocation, the licensee would provide a written notice of Emergency Relocation to the following: -the resident; -the resident's legal representative; -the resident's designated representative; -the resident's case manager as applicable; and -if the resident has been relocated and not returned to [licensee] within four (4) days, the Office of the Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01370	Continued From page 48	01370		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 49 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP-C, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on December 18, 2023, and began providing assisted living services. ULP-C's employee record lacked the required competencies for appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked the required	01370		

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01370	Continued From page 50 competencies for appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting On November 20, 2024, at approximately 12:38 p.m., licensed assisted living director (LALD)-A stated they were unaware that training competencies were incomplete and would contact clinical nurse supervisor (CNS)-B to see if they had been done. The licensee's Staff Competency policy dated August 1, 2021, indicated staff would be required to pass a written examination and demonstrate competence in appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devised; care and use of hearing aids; and dressing and assisting with toileting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 51 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and/or competencies were completed and documented two of two unlicensed personnel ((ULP)-C, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked evidence of completed training and/or competency testing for the following: -basic knowledge of body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 52 appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked evidence of completed training and/or competency testing for the following: -basic knowledge of body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On November 20, 2024, at approximately 12:38 p.m., licensed assisted living director (LALD)-A stated they were unaware that training competencies were incomplete and would contact clinical nurse supervisor (CNS)-B to see if they had been done. The licensee's Staff Competency policy dated August 1, 2021, indicated staff would complete the following training prior to working for [licensee]: -basic knowledge of body functioning and changes in body function, injuries, or other reportable changes; and'-recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01470	Continued From page 53	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 54 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for three of three employees (manager (MGR)-D, unlicensed personnel (ULP)-C, 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) 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:	01470		

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01470	Continued From page 55 MDR-D MGR-D was hired on December 18, 2023, and began providing assisted living services. MGR-D's employee record lacked documentation of the following required orientation topics: -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C ULP-C was hired on January 12, 2024, and began providing assisted living services. ULP-C's employee record lacked documentation of the following required orientation topics: -an overview of assisted living statutes; An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F ULP-F was hired on June 28, 2023, and began providing assisted living services. ULP-F's employee record lacked documentation of the following required orientation topics:	01470		

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01470	Continued From page 56 -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 20, 2024, at approximately 12:10 p.m., licensed assisted living director (LALD)-A stated they were unaware of the required content for orientation and did not know there were components missing from the orientation program. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated orientation topics would include: -an overview of Minnesota Assisted Living Statute 144g and Minnesota Rules Chapter 4659; -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -grievance policy/process, including reports to the Office of Health Facility Complaints; and -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 interview and record review, the licensee failed to ensure the registered nurse (RN) documented ongoing resident monitoring and reassessment of smoking behavior and new interventions when documented interventions failed for three of three residents (R1, R3, R6). In addition, the licensee failed to include all areas required on the uniform assessment tool for three of three residents (R1, R2, R3) and failed to ensure comprehensive nursing assessments	01620		

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01620	Continued From page 58 were completed within the required 90-day time frame for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: SMOKING ASSESSMENT R1 R1 admitted to the licensee on January 30, 2024. R1's diagnoses included schizophrenia, psychotic disorder, a history of methamphetamine abuse, sexual misconduct, and domestic assault via strangulation. R1's service plan dated January 31, 2024, indicated R1 required assistance with dressing, grooming, meals, and medication. The service plan indicated R1 required staff to remind him not to go into other resident rooms uninvited. The service plan indicated R1 required staff to check on him every one hour. The licensee updated R1's service plan on November 18, 2024, and indicated R1 had a history of smoking in his room and staff were to ensure this did not occur. R1's care plan dated November 18, 2024, indicated he had a "Jarvis" order (court issued petition that mandates a resident receive antipsychotic medication without their consent) and required medication administration. The care plan indicated R1 also had a "Price Sheppard"	01620		

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01620	Continued From page 59 (court ordered electroshock therapy (ECT) administered without the resident's consent) and received ECT. The care plan indicated R1 had a poor attention span and poor judgement. The care plan indicated R1 angered easily and was "uncontrollable" and resistive to redirection. The care plan indicated R1 violated sexual boundaries when he was anxious. The care plan indicated R1 was "uncontrollable" when physically aggressive and would damage property. The care plan indicated R1 had a history of smoking in his room. The care plan indicated R1 "lashed out" at others for no reason when he was psychotic. The care plan indicated R1 had a history of consumption of "meth" and other polysubstance drugs. The care plan indicated R1 was easily manipulated, persuaded, and exploited when out in the community to carry out "illegal acts". The care plan indicated staff members were to ensure R1 documented his whereabouts when out in the community. R1's unsigned, undated Smoking Risk Assessment indicated R1's refusal to adhere to facility smoking policies. R1's Progress Notes dated October 15, 2024, through November 18, 2024, indicated R1 was observed by staff smoking in his bedroom on October 17, 2024, and November 3, 4, 8, 14, and 16, 2024. R1's record included Conference Meeting Notes on [R1] dated November 18, 2024, indicating family and resident noncompliance with the smoking agreement. R3 R3 admitted to the licensee on January 31, 2024, and discharged from the licensee on September 24, 2024. R3's diagnoses included schizophrenia	01620		

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01620	Continued From page 60 and cluster B personality disorder. R3's diagnoses included a history of alcohol and marijuana use. R3's service plan dated February 1, 2024, indicated R3 was independent with mobility, but required assistance with dressing and grooming. The service plan indicated he required behavior monitoring daily. R3's care plan, no date, indicated he had poor attention span, and poor judgement. The care plan indicated R3 smoked inside the home and gets verbally aggressive when staff correct him. The care plan also indicated R3 did "drugs" when outside the facility. The care plan indicated R3 angered easily when agitated and violated sexual boundaries when he was anxious. The care plan indicated R3 had verbal outbursts when he was "manic" and required staff to keep objects away from him which could potentially cause harm. The care plan indicated R3 "lashed out" at others for no reason when he was psychotic. The care plan indicated R3 had a history of "meth" consumption, and other polysubstance drugs. The care plan indicated R3 was antisocial, narcissistic, and impulsive. Because R3's care plan was not dated, and handwritten, it is unclear when the licensee identified R3's behaviors, and interventions. R3's Smoking Assessment dated February 1, 2024, indicated R3 smoked in non-designated smoking areas and refused to adhere to licensee's smoking policies. R6 R6 was admitted on September 23, 2019, under the licensee's former comprehensive license and began receiving assisted living services on	01620		

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01620	Continued From page 61 August 1, 2024. R6's diagnoses include schizophrenia, psychosis, and anxiety. R6's Service Plan dated February 29, 2024, indicated R6's services included mealtime assistance, medication management, and behavioral management. R6's Care Plan revised September 14, 2024, indicated R6 smoked in the closet of his room and had a history of setting his room on fire. R1, R3, and R6's records lacked documentation of ongoing reassessment and monitoring and new interventions when unsafe smoking behavior continued and current interventions were insufficient. On November 19, 2024, at approximately 2:30 p.m., unlicensed personnel (ULP)-C stated there were five residents who smoked in the house and were on safety checks every two hours. ULP-C stated safety checks were not documented. On November 20, 2024, at approximately 12:25 p.m., LALD-A stated they try to manage indoor smoking issues through safety checks every two hours and R1 had recently been increased to hourly safety checks. UNIFROM ASSESSMENT TOOL/TIMING OF ASSESSMENTS R1 R1's nursing assessment dated April 1, 2024, indicated the assessment was a routine 90-day assessment. The assessment was a two-page abbreviated assessment and did not indicate the registered nurse (RN) reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool	01620		

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01620	Continued From page 62 elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -mobility status; -eating, dental status, oral care; -housework; -laundry; -transportation; -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. R1's record included consecutive assessments completed on April 1, 2024, and July 1, 2024, indicated 91 days passed between assessments. R1's consecutive assessments completed on July 1, 2024, and October 30, 2024, indicated 121 days passed between assessments. R2 R2 admitted to the licensee on January 26, 2024. R2's diagnoses included generalized anxiety disorder, major neurocognitive disorder, depressive disorder, hypertension, insulin	01620		

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01620	Continued From page 63 dependent diabetes mellitus (IDDM), chronic obstructive pulmonary disease (COPD), kidney disease, alcoholism, coronary artery disease, pacemaker, and stent. R2's service plan dated January 26, 2024, indicated he was a fall risk and used a wheelchair and a walker. R2's care plan dated September 27, 2024, indicated R2 required mobility assistance from staff for all cases and mobility because he had a closed right ankle fracture and acute traumatic pain. The care plan indicated R2 was non-weight bearing on his right leg. R2's record included consecutive assessments completed on February 16, 2024, and July 3, 2024, indicated 137 days passed between assessments. R2's nurse reassessment dated September 27, 2024, failed to include the signature of the RN. The assessment was a two-page abbreviated assessment and did not indicate the RN reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -eating, dental status, oral care; -housework; -laundry; -transportation;	01620		

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01620	Continued From page 64 -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. R3 R3's nursing assessment dated July 1, 2024, indicated the assessment was a routine 90-day assessment. The assessment was a two-page abbreviated assessment and did not indicate the RN reviewed the most recent comprehensive assessment. The assessment failed to include the following assessment tool elements: -sleep schedule; -dietary needs; -social needs; -spiritual preferences; -advanced health directives; -toileting pattern; -dressing, bathing, grooming, and personal hygiene; -eating, dental status, oral care; -housework; -laundry; -transportation; -review of medical and nursing diagnoses; -allergies; -current memory, orientation, confusion, and decision-making status; -nutritional and hydration status; -nursing needs, including potential to receive nursing-delegated services;	01620		

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01620	Continued From page 65 -risk indicators; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use. On November 20, 2024, at 12:11 p.m., licensed assisted living director (LALD)-A acknowledged the licensee's universal assessment form lacked required content per Minnesota Administrative Rule 4659.0150. On November 20, 2024, at 12:43 p.m., LALD-A said she was unaware the nursing assessments for R1 and R2 exceeded the 90-day requirement. LALD-A acknowledged the nursing assessments should not exceed the 90-day time frame. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated a RN would complete ongoing resident assessments, not to exceed 90 days. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated a RN would complete comprehensive assessments for all residents admitted to the licensee, utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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01640	Continued From page 66 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and by the resident or resident's representative to document agreement of services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01640		

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01640	Continued From page 67 The findings include: R1 R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1's services included assistance with dressing, grooming, meals, behavior management, hourly safety checks, and medication administration. R2 R2 was admitted January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2 received services including mealtime assistance, behavioral management, and medication management. R3 R3 was admitted on January 31, 2024, and began receiving assisted living services. R3's Service Plan dated February 1, 2024, indicated R3 received services including mealtime assistance, behavior management, and medication administration. R1, R2, and R3's Service Plans lacked authentication by the resident or representative indicating agreement with the services to be provided. On November 20, 2024, at 12:43 p.m., licensed assisted living director (LALD)-A stated they add revisions to the existing service plan and note the dates of update under the care plan review. LALD-A stated they do not have the resident or	01640		

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01640	Continued From page 68 resident representatives sign the service plan when developed or revised and that they verbally inform the resident representatives of the changes. The licensee's Service Plan policy dated August 1, 2021, read the initial service plan and any revisions are signed by a representative from [licensee]and the resident or resident's representative, indicating agreement with the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication	01760		

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	24780	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 69 administration in residents' records for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 number or all the residents). The findings include: R1 R1 was admitted on January 30, 2024, and began receiving assisted living services. R1's Service Plan dated January 31, 2024, indicated R1's services included medication management and administration. R1's record included a Medication Administration Record (MAR) dated November 2024. The MAR indicated the licensee failed to document administration or refusal of the following medications between November 1, 2024, through November 17, 2024: -olanzapine 10 milligrams (mg); take one (1) tablet by mouth (PO) three times daily. The licensee failed to document the 7:30 a.m. dose 1 out of 17 days, failed to document the 12:00 p.m. dose two (2) out of 17 days, and failed to document the 8:30 p.m. dose 2 out of 17 days. - polyethylene glycol; take 17 grams PO two times daily. The licensee failed to document the 7:30 a.m. dose 1 out of 17 days, and failed to document the 7:30 p.m. dose 1 of 17 days. -senna 8.6 mg tablets; take 2 tablets PO twice daily. The licensee failed to document the 7:30	01760		

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01760	Continued From page 70 a.m. dose 1 of 17 days and failed to document the 7:30 p.m. dose 1 of 17 days. R2 R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2's services included medication management and administration. R2's record included a MAR dated November 2024. The MAR indicated the licensee failed to document administration or refusal of the following medications between November 1, 2024, and November 17, 2024: -gabapentin 300 mg capsules; Take 1 capsule PO every 12 hours. The licensee failed to document at 7:30 p.m. on 1 of 17 days. -Humalog insulin 100 units (U)/milliliter (ml); Inject 10 U under skin three times daily. The licensee failed to document the 2:00 p.m. dose 14 out of 17 days, and failed to document the 8:30 p.m. dose 4 out of 17 days. -hydrocortisone 1% cream; apply topically four times daily for skin irritation; the licensee failed to document the 8:00 a.m. dose on 1 out of 17 days, failed to document the 12:00 p.m. dose 14 out of 17 days, failed to document the 4:00 p.m. dose 17 out of 17 days, and failed to document the 8:00 p.m. dose on 5 out of 14 days. -Lantus insulin 100 U/ml; inject 14 U under the skin at bedtime. The licensee failed to document the 7:30 p.m. dose on 3 of 17 days. -metformin 500 mg tablets; Take 1 tablet PO two times daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -methocarbamol 500 mg tablet; take 1 tablet PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days.	01760		

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01760	Continued From page 71 -metoprolol tartrate 25 mg tablet; take 1 tablet twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -mirtazapine 7.5 mg tablet; take 1 tablet PO at bedtime. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -Prerservision Areds capsules; take 1 capsule PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days. -ranolazine 500 mg tablets; take one tablet PO twice daily. The licensee failed to document the 7:30 p.m. dose on 1 of 17 days; and -rosuvastatin 40 mg tablet; take 1 tablet PO daily. The licensee failed to document the 7:30 a.m. dose on 3 of 17 days. On November 20, 2024, at 12:55 p.m., licensed assisted living director (LALD)-A stated they were unaware that medication administration or refusals were not being documented in the MARs. LALD-A stated that staff may document refusals in the progress notes. The licensee's Medication Documentation policy dated August 1, 2021, read "if the administration of one or more medications was not completed, staff will document the following: a. The reason why the medication was not administered; b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan; c. Appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and d. Medication Error report, if appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 72 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 store all prescription medications according to the manufacturer's directions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 19, 2024, at approximately 12:55 p.m., the surveyor observed a countertop refrigerator in the locked medication room. The refrigerator did not have a locking mechanism. Contents of the refrigerator included insulin for R2 (two boxes of Humalog insulin, one full and one containing an unused insulin pen and one unopened box of Lantus insulin. The refrigerator contents also included an opened package of beef jerky sticks. The floor of the refrigerator had standing water. The refrigerator contained a	01880		

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01880	Continued From page 73 thermometer which was not functioning. On November 19, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-A removed the food item and the box of Lantus insulin from the refrigerator. LALD-A stated the food should not be stored in the refrigerator. LALD-A stated they did not monitor the temperature of the refrigerator and had been told that it was not necessary. LALD-A verified the thermometer was not working and they removed it from the refrigerator. LALD-A stated they would replace the thermometer and begin monitoring refrigerator temperatures. The Lantus package insert developed by Sanofi-Aventis and revised June 2023, indicated the following instructions for storage: -store unused Lantus between 2° to 8° Celsius (C) (36° to 46° Fahrenheit (F)) in a refrigerator; -do not freeze. Discard Lantus if it has been frozen; -protect Lantus from direct heat or light; -Lantus that has been opened (refrigerator or room temperature) should be discarded after 28 days. The Humalog Kwik-Pen® Instructions for Use developed by Eli Lilly Company and revised July 2023, indicated the following instructions: - store unused pens in a refrigerator at 36° to 46° F (between 2° to 8° C); -do not freeze insulin and do not use if frozen; and -unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all	01880		

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01880	Continued From page 74 prescription drugs would be stored securely locked in substantially constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon	01910		

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01910	Continued From page 75 discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the facility on January 31, 2024, and discharged on September 24, 2024. R3's diagnoses included schizophrenia, personality disorder, and a history of alcohol and marijuana abuse. R3's Service Plan dated February 1, 2024, indicated R3's services included behavior monitoring and medication management and administration. R3's record included a Medication Administration Record dated August 2024, which indicated R3 had been administered the following medications: -fluoxetine 10 milligrams (mg) by mouth (PO) daily; -haloperidol 5 mg tablets; two tablets PO twice daily; -olanzapine 20 mg PO at bedtime; and -trazodone 100 mg PO at bedtime. R3's record lacked documentation of disposition of medications at the time of discharge. On November 19, 2024, at approximately 4:00	01910		

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01910	Continued From page 76 p.m., the surveyor requested documentation of medication disposition for R3. Licensed assisted living director (LALD)-A stated they would request the information from clinical nurse supervisor (CNS)-B. LALD-A stated "he [R3] always refused his medication". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 77 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 November 18, 2024, at approximately 2:00 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with a blood sugar check by handing him supplies as he performed a finger stick and checked his blood sugar. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated R2's services included behavioral monitoring, medication management and administration, and wound care provided by a	01940		

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01940	Continued From page 78 third party. R2's service plan did not include blood glucose monitoring as a service received by R2. R2's undated Treatment Plan indicated R2 received blood glucose monitoring. R2's treatment plan lacked the following required content: -documentation of specific resident instructions related to the treatment or therapy administration; and -any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On November 19, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated they were unaware R2's treatment plan was not complete and would notify clinical nurse supervisor (CNS)-B. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which would address the following: -type of service to be provided; -procedures for documenting treatments or therapies- -procedures for monitoring treatments or therapies to precent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed personnel; and -procedures for notifying the RN when a problem arises related to the treatment or therapy service.	01940		

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01940	Continued From page 79 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of administration of or the reason why a treatment was not administered and any follow-up procedures that were provided for one of one resident (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01960		

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01960	Continued From page 80 The findings include: On November 18, 2024, at approximately 2:00 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with a blood sugar check by handing him supplies as he performed a finger stick and checked his blood sugar. R2 was admitted on January 26, 2024, and began receiving assisted living services. R2's Service Plan dated January 26, 2024, indicated blood glucose monitoring was not included in services received by R2. R2's record included an undated Treatment Management Plan which indicated R2 received blood glucose checks at a frequency per MD order. R2's record included a Daily Blood Sugar Tracker with blood glucose results recorded between November 1, 2024, through November 18, 2024. R2's Daily Blood Sugar Tracker lacked documentation of a blood sugar result for November 3, 4, 6, and 8, 2024. The surveyor requested R2's prescriber orders on November 18, 2024, at 3:45 p.m., November 19, 2024, at 10:45 a.m., November 19, 2024, at 4:00 p.m., and November 20, 2024, at 2:20 p.m. The surveyor did not receive prescriber orders for R2 prior to the close of the survey on November 26, 2024. On November 20, 2024, licensed assisted living director (LALD)-A stated R2's orders for blood glucose checks had recently been decreased from three times daily to twice daily. LALD-A stated they were unaware the blood glucose	01960		

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01960	Continued From page 81 results were not documented as ordered and stated they would check with clinical nurse supervisor (CNS)-B. The licensee's Treatment and Therapy Management policy dated August 1, 2021, read "when a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered, and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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	24780	A. BUILDING: _____ B. WING _____	C 10/25/2024

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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: #HL247806520C #HL247808703C/#HL247806061M On October 9, 2024 through October 25, 2024,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 14 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL247806520C, tag identification 1600 and #HL247808703C/#HL247806061M, tag identification 2310, 2360.	0 000	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.	
01600 SS=G	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and	01600		

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	24780	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

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01600	Continued From page 1 numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure staff had the sufficient qualifications, competency, and numbers to adequately provide the services agreed to in the assisted living contract prior to admission of one of one resident (R1) who had a history of mental health disorders, elopements, and a history of substance abuse. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 admitted to the facility with a history of elopements, medication non-compliance, and mental health diagnoses and behaviors that required monitoring, medication management, behavior and mental health management, and monitoring for self-injurous behaviors. R1's medical record identified these areas; however, licensee staff did not implement identified interventions, follow R1's careplan or mental health management plan, address behaviors, or implement interventions to protect R1's safety following mulitiple elopements from the facility. R1's medical record indicated R1 admitted to the	01600		

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01600	Continued From page 2 licensee on March 19, 2019, with the diagnoses of schizophrenia. R1's care plan dated March 1, 2024, indicated R1 was under civil commitment (court ordered institutionalization). R1's care plan indicated staff were to provide medication management, medication administration, mental health management, dressing, bathing, and grooming assistance, and housekeeping. R1's care plan included under mental health management identified monitoring R1 for self-injurious behaviors, monitor for hallucinations, history of leaving the licensee and not returning for more than two-days for which staff would follow the licensee's missing person policy. The staff should notify R1's provider if R1 leaves for more than two-days for a medication review, including R1's order for Clozaril (mental health medication). Staff encouraged R1 to sign-out, encourage R1 to wear a Belle Pendent, (used to call 911), Staff to complete daily rounds every one to two hours, monitor how much time is spent on the licensee's phone, monitor 911 calls, monitor for substance abuse including cocaine, methamphetamines and cannabis. Monitor R1 for dangerous behaviors to obtain substances. Monitor R1 for paranoia for which R1 prefers one-to-one visits. Staff to ask R1 for an as needed, (PRN), medication to alleviate hallucinations. R1's behavior plan dated April 23, 2024, (unsigned), indicated R1 had a history of the following behaviors: verbal abuse, agitation, repetitive behaviors, going into other's rooms, anxiety, confrontational, hallucinations, property destruction, multiple 911 calls, threatens staff, threatens other residents, pacing, self-neglect, elopements and drug abuse. Interventions included: redirections, staff one-to-one, fifteen	01600		

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01600	Continued From page 3 minute to two-hour safety checks for anxiety, quiet space, complete a missing person report and call 911 if R1 elopes. A July 15, 2024, civil commitment document for R1 indicated R1 had not followed her provisional discharge plan, including leaving the licensee on a few occasions without notifying staff, thus missing oral medications or being late on her scheduled long-acting injections and has admitted to using drugs provided to her. The commitment documented indicated R1 had a history of substance abuse and suicidal ideation. R1 was receiving individual home supports, (IHS), with nine hours of training weekly while the IHS supports assist with shopping, activities, and training on personal skills. R1 had a psychiatric provider and orders for Clozaril, Prolixin, and a long acting injectable, (LAI), form of Prolixin. R1 had a JARVIS, (an order that allows a medical professional to request a resident receive psychiatric medications against their will) order despite agreeing to be compliant with medications. The document indicated R1 was to remain under civil commitment at this time. A nursing re-assessment completed on July 24, 2024, indicated R1 frequently left the facility and does not return. The assessment indicated staff met with R1 to discuss when leaving the licensee, to call staff to check-in on R1's whereabouts and consistency with taking prescribed medications if out for extended periods, all to which R1 agreed to understanding. The assessment indicated the licensee made frequent calls to law enforcement (LE) to file missing person reports and indicated R1 was to call staff if she would be out more than a twenty-four hours. R1's service plan dated July 24, 2024, indicated	01600		

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01600	Continued From page 4 R1 received daily assistance with dressing, grooming, toileting, stand by assist (SBA) with mobility, medication management, behavior monitoring, housekeeping, and laundry. R1's individual abuse prevention plan, (IAPP), dated September 1, 2024, indicated R1 was an elopement risk and at risk for sexual abuse. The IAPP indicated R1's mental health and independent decision-making placed R1 in vulnerable situations when leaving the licensee. R1's risk factors included the following: diagnoses of schizoaffective disorder leads to disorganized thinking, mood instability and delusions. R1 had a tendency to elope, substance use disorder, specifically when R1 leaves the licensee. Interventions included: discuss boundaries with R1, encourage R1 to leave the licensee with staff or IHS worker. Staff encouragement of continued education to R1 regarding safety when not in the licensee, including provided communication devices, even though R1 expressed that she does not want her whereabouts known and preferred not to be contacted. Staff would work with R1's psychiatrist to ensure medication for schizoaffective disorder are monitored, reviewed and adjusted PRN to assist in mood stability, delusion reductions, decreased disorganized thoughts and vulnerability. Encourage R1 to attend regular mental health check-ins to assess effectiveness of the treatment plan. Staff would monitor, remove R1 from an incident, report, assess and offer medical evaluation for any signs of abuse. A review of R1's progress notes indicated R1 eloped from the facility on the following dates: -May 4, 2024 -May 15, 2024 -May 23, 2024	01600		

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01600	Continued From page 5 -May 26, 2024 -May 31, 2024 -June 1, 2024 -June 3, 2024 -July 17, 2024 -August 2, 2024 -August 9, 2024 -August 13, 2024 -August 17, 2024 -August 26, 2024 -September 5, 2024 -September 10, 2024 R1's IAPP was not updated to include each elopement and the IAPP interventions were not followed by licensee staff. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. R1's medical record did not include consistent or detailed information of R1's elopements including the last time R1 was seen at the facility, how long R1 was missing, when R1 returned to the facility, who was contacted regarding the elopement or return of R1, or action taken to search for R1. Upon R1's returns to the facility, there was no indication of an assessment completed of R1 or additional interventions or supervision implemented to ensure R1's safety. R1's medical record lacked documentation to indicate staff implemented mental health interventions identified on R1's care plan and behavior monitoring plan and following multiple elopements and law enforcement interactions, R1's care plan and/or behavior monitoring plans were not re-evaluated or updated to reflect R1's current status or more effective interventions or	01600		

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01600	Continued From page 6 approaches. A review of law enforcement records included an undated law enforcement letter sent to the facility, indicated a caution to all parties concerning R1, that when R1 was reported a missing person, licensee services could not have been provided as R1 was not in the licensee and indicated the licensee could not bill for services. A law enforcement, (LE), report dated July 19, 2024, at 10:15 a.m., indicted that a LE officer and law enforcement mental health coordinator, (LE)-F, responded to the licensee regarding R1's July 17, 2024 elopement. Licensee staff informed LE that R1 did not sign out, they did not know R1's whereabouts, informed that R1 would often check herself into an area hospital. This report indicated LE-F checked with the area hospital and R1 was not admitted there. This report indicated R1's elopements were a reoccurring concern, R1 leaves for a few days at a time, and had a history of using illicit substances, the licensee had not made any efforts to locate R1. LE was informed by the licensee that a missing person's policy was being reviewed by licensee administrative staff and not yet being utilized and LE would be reporting the incident(s) as a vulnerable adult neglect concern. Law enforcement records also included a report dated July 28, 2024, at 1:00 p.m., which indicated the licensee called to report R1 missing. LE informed the licensee of the ongoing issue of R1 leaving the facility, staff not knowing or showing concern for R1's safety or misuse of emergency resources when R1 had repeated been reported as a missing person when R1 had left the licensee.	01600		

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01600	Continued From page 7 During an interview dated October 23, 2024, at 11:03 a.m., a law enforcement officer (LE)-F stated R1 has been involved in a high volume of LE calls and responses. LE-F stated R1 has had thirty-seven missing persons cased from the year 2019 to present. LE-F stated R1 is not transparent where she is going and the licensee policy is to use the sign-in/sign-out sheet. LE-F stated when R1 leaves the licensee, the licensee calls to report a missing person, R1 returns a couple of days later then R1 is taken out of LE's missing persons system. LE-F stated the licensee does not follow the licensee's missing person protocol. LE-F stated that on July 26, 2024, the licensee falsified an incident report regarding R1's elopement. LE-F stated the licensee documented following missing person's protocol but actually do not follow their own policy. LE-F recalled at one time, another city's LE found R1 and called their LE agency. LE-F stated when the licensee was informed R1 was in another city, the licensee stated that they would not pick-up R1 so LE had to return R1 back to the licensee. LE cannot bill for the transportation of R1 back to the licensee. The licensee had met with LE regarding the multiple elopements and quality of R1's care concerns. During an interview on October 25, 2024 at 1:34 p.m., the licensed assisted living director (LALD) acknowledged R1 had multiple elopments from the facility and that law enforcement had been contacted multiple times and had met with facility administration regarding concerns over R1 and R1's frequent elopements. No further information provided. Time Period for Correction: Seven (7) Days.	01600		

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02310	Continued From page 8	02310		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs in accordance with an up-to-date service plan and accepted health care standards for one of one resident (R1) with a known history of elopement. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's medical record indicated R1 admitted to the licensee on March 19, 2019, with a diagnosis of schizophrenia. R1's care plan dated March 1, 2024, indicated R1 was under civil commitment (court ordered institutionalization) at the facility. R1's care plan indicated staff were to provide medication	02310		

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02310	Continued From page 9 management, medication administration, mental health management, dressing, bathing, grooming assistance, and housekeeping. R1's care plan included mental health management and identified monitoring R1 for self-injurious behaviors, monitoring for hallucinations, history of leaving the licensee and not returning for more than two-days and directed for staff to follow the licensee's missing person policy. Staff should notify R1's provider if R1 leaves for more than two-days for a medication review, including R1's order for Clozaril (mental health medication). Staff were to encouraged R1 to sign-out, encourage R1 to wear a Belle Pendent, (used to call 911), Staff to complete daily rounds every one to two hours, monitor how much time is spent on the licensee's phone, monitor 911 calls, monitor for substance abuse including cocaine, methamphetamines and cannabis. Monitor R1 for dangerous behaviors to obtain substances. Monitor R1 for paranoia for which R1 prefers one-to-one visits. Staff to ask R1 about as needed, (PRN), medication to alleviate hallucinations. R1's behavior plan dated April 23, 2024, indicated R1 had a history of the following behaviors: verbal abuse, agitation, repetitive behaviors, going into other's rooms, anxiety, confrontational, hallucinations, property destruction, multiple 911 calls, threatens staff, threatens other residents, pacing, self-neglect, elopements and drug abuse. Interventions included: redirections, staff one-to-one, fifteen minute to two-hour safety checks for anxiety, quiet space, complete a missing person report and call 911 if R1 elopes. A review of R1's progress notes indicated R1 eloped from the facility on the following dates:	02310		

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02310	Continued From page 10 -May 4, 2024 -May 15, 2024 -May 23, 2024 -May 26, 2024 -May 31, 2024 -June 1, 2024 -June 3, 2024 R1's medical record did not indicate that staff contacted R1's provider regarding R1's missed medications following each elopement as indicated in R1's careplan. R1's record included no documentation of staff monitoring R1 for self-injurous behaviors, substance use, or elopements, and included no indication of staff following R1's behavior plan including completing 1:1 visits, or additional safety checks. R1's care plan was not updated following the multiple elopements in May and June 2024. R1's IAPP was not updated following the May and June 2024 elopements. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. A nursing re-assessment completed on July 24, 2024, indicated R1 frequently left the facility and did not return. The assessment indicated staff met with R1 to discuss when leaving the licensee, to call staff to check-in on R1's whereabouts and consistency taking prescribed medications if out for extended periods, all to which R1 agreed to understanding. The assessment indicated the licensee made frequent calls to law enforcement (LE) to file missing person reports and indicated R1 was to call staff if she would be out more than a twenty-four hours.	02310		

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02310	Continued From page 11 R1's service plan dated July 24, 2024, indicated R1 received daily assistance with dressing, grooming, toileting, stand by assist (SBA) with mobility, medication management, behavior monitoring, housekeeping, and laundry. R1's medical record indicated R1 continued to have multiple elopements from July through September 2024. R1's progress notes indicated the following elopements: -July 17, 2024 -August 2, 2024 -August 9, 2024 -August 13, 2024 -August 17, 2024 -August 26, 2024 -September 5, 2024 -September 10, 2024 Further review of R1's medical record and service delivery records indicated staff documented services provided inconsistently and documented services provided during the duration of some of the elopements, despite documenting in progress notes that R1 was not at the facility and documenting that medications were not administered due to R1 not being in the facility. R1's medical record did not indicate that staff contacted R1's provider regarding R1's missed medications following each elopements as indicated in R1's care plan. R1's record included no documentation of staff monitoring R1 for self-injurious behaviors, substance use, or elopements and included no indication of staff following R1's behavior plan, completing 1:1 visits, or additional safety checks. R1's care plan was not updated following the multiple elopements in July, August, and September 2024.	02310		

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02310	Continued From page 12 R1's individual abuse prevention plan, (IAPP), dated September 1, 2024, indicated R1 was an elopement risk and at risk for sexual abuse. The IAPP indicated R1's mental health and independent decision-making placed R1 in vulnerable situations when leaving the licensee. R1's risk factors included the following: diagnoses of schizoaffective disorder leads to disorganized thinking, mood instability and delusions. R1 had a tendency to elope, substance use disorder, specifically when R1 leaves the licensee. Interventions included: discuss boundaries with R1, encourage R1 to leave the licensee with staff or IHS worker. Staff encouragement of continued education to R1 regarding safety when not in the licensee, including provided communication devices, even though R1 expressed that she does not want her whereabouts known and preferred not to be contacted. Staff would work with R1's psychiatrist to ensure medication for schizoaffective disorder are monitored, reviewed and adjusted PRN to assist in mood stability, delusion reductions, decreased disorganized thoughts and vulnerability. Encourage R1 to attend regular mental health check-ins to assess effectiveness of the treatment plan. Staff would monitor, remove R1 from an incident, report, assess and offer medical evaluation for any signs of abuse. R1's IAPP was not updated to include each elopement and the IAPP interventions were not followed by licensee staff. No additional assessment of R1 was completed following the multiple elopements and no additional supervision was implemented to ensure R1's safety. R1's medical record did not include consistent or detailed information of R1's elopements including	02310		

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02310	Continued From page 13 the last time R1 was seen at the facility, how long R1 was missing or length and time of each elopmen, when R1 returned to the facility, if anyone was contacted regarding the elopement or return of R1, or action taken to search for R1. Upon R1's returns to the facility, there was no indication of an assessment completed of R1 or additional interventions or supervision implemented to ensure R1's safety. R1's progress note dated September 5, 2024 2:05 p.m. indicated staff held a collaborative meeting with the law enforcement mental health coordinator, (LE)-F and R1's mental health case manager (CM)-D. R1 refused to attend. The note indicated changes suggested during the meeting regarding the licensee's sign-out sheets would be implemented. A review of law enforcement records included an undated law enforcement letter sent to the facility, indicated a caution to all parties concerning R1, that when R1 was reported a missing person, licensee services could not have been provided as R1 was not in the building at the time and indicated the licensee could not bill for services. Law enforcement records also included a report dated July 28, 2024, at 1:00 p.m., which indicated the licensee called to report R1 missing. LE informed the licensee of the ongoing issue of R1 leaving the facility, staff not knowing or showing concern for R1's safety or misuse of emergency resources when R1 had repeatedly been reported as a missing person when R1 had left the licensee. A law enforcement report dated August 15, 2024, at 9:28 a.m., indicated the licensee called LE and when LE attempted to speak with licensee's staff	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

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02310	Continued From page 14 regarding R1's elopement, the staff called another staff member but LE was unable to hear the name of the staff called. LE gave staff LE's work cell number and requested the staff to call LE directly. There was no return call to LE, LE attempted to call the licensee twice and there was no answer. A law enforcement report dated August 15, 2024, at 1:25 p.m., indicated LE was contacted regarding R1. LE was informed that R1 left on August 13, 2024 at 4:51 p.m. Licensee staff informed LE that they had attempted to call area hospitals and completed a community search without success in finding R1. Staff informed LE that R1 did not sign-out and reviewed the licensee's cameras. Staff informed LE that R1 was free to come and go as she wished. LE informed the licensee that since year 2019, R1 had eloped thirty-one times and LE was dispatched. LE inquired with staff on how someone on a civil commitment is allowed to come and go freely. LE reminded staff regarding the incident on August 10, 2024, in which, staff refused to pick-up R1 after being located in another city. The report indicated LE attempted to call R1's case manager twice, (CM)-D, but only received her voice mail and a message was left by LE to return a call. A law enforcement report dated August 27, 2024, at 9:15 p.m., indicated LE received a call that R1 left the licensee and had not returned. The report indicated R1 left the licensee on August 26, 2024, at 3:00 p.m. and had not returned. Staff informed LE that licensee protocol was followed included driving around looking for R1 August 27, 2024, but the search excluded a location R1 frequented. Staff informed LE that he did not have a clothing description, access to the licensee's cameras,	02310		

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02310	Continued From page 15 and R1 had a sign-out entry that indicated 3:00 p.m. no signature, no date, no information. A law enforcement report dated September 9, 2024, indicated LE completed a missing person report and included that R1 frequently eloped from the licensee, had a mental health diagnoses, was a known drug user and court ordered to be at the licensee. A law enforcement (LE) report provided to the MDH investigator via email on October 23, 2024 at 11:38 a.m., indicated there was a minimum of twenty days between March 12, 2024 and July 31, 2024, services could not have been provided as R1 was not in the licensee receiving services due to being a missing person, therefore services could not be billed. During an interview dated October 23, 2024, at 11:03 a.m., a law enforcement officer (LE)-F stated R1 has been involved in a high volume of LE calls and responses. LE-F stated R1 has had thirty-seven missing persons cased from the year 2019 to present. LE-F stated R1 is not transparent where she is going and the licensee policy is to use the sign-in/sign-out sheet. LE-F stated when R1 leaves the licensee, the licensee calls to report a missing person, R1 returns a couple of days later then R1 is taken out of LE's missing persons system. LE-F stated the licensee does not follow the licensee's missing person protocol. LE-F stated that on July 26, 2024, the licensee falsified an incident report regarding R1's elopement. LE-F stated the licensee documented following missing person's protocol but actually do not follow their own policy. LE-F recalled at one time, another city's LE found R1 and called their LE agency. LE-F stated when the licensee was informed R1 was in another city, the	02310		

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02310	Continued From page 16 licensee stated that they would not pick-up R1 so LE had to return R1 back to the licensee. LE cannot bill for the transportation of R1 back to the licensee. The licensee had met with LE regarding the multiple elopements and quality of R1's care concerns. During an interview on October 24, 2024, at 1:08 p.m., R1 stated she desired to be more independent and is working on getting a case manager that is closer to her location. R1 stated she is looking to get a job. R1 stated is should not be an issue if she goes into the community independently. It is not of the licensee's business. R1 stated when she did leave the licensee, she did tell them where she went. R1 stated she alerts people that should know but knows "they" are leaking it to the cops, including the "thief catching department" that is currently investigating my whereabouts. R1 stated she never leaves the licensee unless she is going to people's houses to sleep at night. R1 stated she usually goes to a church that is open between 8:00 a.m. and 4:30 p.m. or the malls. R1 stated she had a bus card for transportation provided by CM-D. During an interview dated October 21, 2024, at 1:02 p.m., R1's case manager (CM)-D stated R1 agreed to follow the licensee's rules, including utilization of the licensee's sign-out/sign-in form. CM-D stated being aware that R1's signing-out when leaving had not improved. CM-D stated R1 was provided a cellular phone but had lost it or traded it for drugs. CM-D stated R1 would freely admit when using substances. CM-D was currently seeking a more independent setting for R1 even though that type of setting has not gone well for R1.	02310		

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02310	Continued From page 17 During an interview dated October 25, 2024, at 1:34 p.m., Licensed assisted living director, (LALD)-A, stated R1 was good at coming and going out of the building. R1 may have come back and left the facility again during some of the dates of documented elopements, however, LALD-A did not have the documents in front of her to refer to and would have to review them later. The MDH investigator inquired why the licensee's sign-out sheets dated July 2024 to September 2024, were not received via the investigator's Minnesota Department of Health (MDH), email address, LALD-A stated the licensee may not have been using the sign-out sheets as regularly for those months, but LALD-A would check on it. No further information was provided. Time Period for Correction: Seven (7) Days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred	02360		

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02360	Continued From page 18 and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *11/19/24*
Time: 09:38:48
Report: 1023241266

Food and Beverage Establishment Inspection Report

Location:
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038508
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635613434
ID #:

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

The following orders previously issued on 04/06/22 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MEASURED COOKED EGG IN REACH IN COOLER #1 ABOVE 41dF. ALWAYS KEEP FOOD AT SAFE TEMPERATURES. INSTRUCTED STAFF TO DISCARD FOOD AND REPAIR EQUIPMENT.

Issued on: 04/06/22 *Comply By: 04/06/22*

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

CABINETRY HAS EXPOSED WOOD. COUNTER TOPS ARE CERAMIC TILE WITH ABSORBENT GROUTING. COUNTER TOP TILES ARE BROKEN.

Issued on: 04/06/22 *Comply By: 04/06/22*

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

MEASURED COOKED EGG IN REACH IN COOLER #1 ABOVE 41dF. ALWAYS KEEP FOOD AT SAFE TEMPERATURES. INSTRUCTED STAFF TO DISCARD FOOD AND REPAIR EQUIPMENT.

Issued on: 04/06/22 *Comply By: 04/06/22*

Type: Full
Date: *11/19/24*
Time: 09:38:48
Report: 1023241266
Amazing Love Assisted Living

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

Process/Item: Cold Hold/EGG
Temperature: 50 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: Yes

Process/Item: Cold Hold/SAUCE
Temperature: 50 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: Yes

Process/Item: Cold Hold/CHEESE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER #3
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS

Food and Beverage Establishment Inspection Report

- ANSI 184 DISH WASHER

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023241266 of 11/19/24.

Certified Food Protection Manager: ADEYEMI OSONOWO

Certification Number: 85522 Expires: 08/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

MADALYN KOENEN
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us