Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION OF CONDITIONAL LICENSE

Electronically Delivered

April 22, 2026

Licensee
Westwood Place Inc
209 Jefferson Avenue Southwest
Watertown, MN 55388

RE: Conditional License Number 417362
Health Facility Identification Number (HFID) 30328
Project Number(s) SL30328016

Dear Licensee:

On February 5, 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 on September 12, 2025. 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 extending the conditional assisted living facility license with dementia care for an additional 60-days, due to expire on **June 21, 2026**.

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 September 12, 2025, found not corrected at the time of the February 5, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $1,000.00
1290-Background Studies Required-144g.60 Subdivision 1 - $1,000.00
1350-Temporary Staff-144g.60 Subd. 5 - $500.00

The details of the violations noted at the time of this follow-up survey completed on February 5, 2026 (listed

above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on February 5, 2026, we identified the following violation(s):

1500-Required Annual Training-144g.63 Subd. 5
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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.

CONDITIONAL LICENSE ISSUED:
MDH will extend the conditional assisted living **with dementia care** facility license for Westwood Place Inc, for an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 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 Westwood Place Inc is in substantial compliance.

The following conditions will continue to be in effect on the conditional assisted living facility with dementia care license:

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. **Consultant:** Westwood Place Inc will continue to contract with an RN to provide consultation concerning all resident(s) to whom Westwood Place Inc provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Westwood Place Inc. The consultant will continue to 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. The RN must continue to not have any affiliation with Westwood Place Inc. Westwood Place Inc is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Westwood Place Inc in an effort to help Westwood Place Inc 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. Westwood Place Inc will continue to 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.

c. **Reports:** The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Westwood Place Inc 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).

d. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Westwood Place Inc to correct the violations cited during the follow-up survey as well as to determine the overall practice of Westwood Place Inc 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.

e. 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 4 or 5 violations or widespread care related violations.

f. Corrective Action Plan: Westwood Place Inc will continue to 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 Westwood Place Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional license period. If MDH determines Westwood Place Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Westwood Place Inc's assisted living facility license, and Westwood Place Inc will correct any outstanding violations identified during the survey. If Westwood Place Inc 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. § 144G20, Subd. 14, a request for a hearing must be in writing and 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 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 submit a request for 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 Kelly Thorson directly at: 320-223-7336 or email at: Kelly.Thorson@state.mn.us.

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
	30328	A. BUILDING: _____ B. WING _____	R 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30328016-1 On February 3, 2026, through February 5, 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 27 residents receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued and/or 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.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	{0 775}		

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{0 775}	Continued From page 1 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:	{0 775}	Not reviewed during this survey	
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 2 This MN Requirement is not met as evidenced by: Not reviewed during this survey	{0 780}		
{0 790} SS=C	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: Not reviewed during this survey	{0 790}		
{0 810} SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	{0 810}		

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{0 810}	Continued From page 3 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: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	{0 810}		

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{0 810}	Continued From page 4 On Febuary 3, 2026 at approximatly 1:00 p.m., the surveyor spoke with the facility licensed assisted living director (LALD)-A. During the interview LALD-A stated she had an issue with licensing and would not provide documentation indicating the staff and resident trainings were completed. FINDINGS FROM INITIAL SURVEY: The findings include: On September 8, 2025, licensed assisted living director (LALD)-A emailed documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP was not located onsite in a central location where it was readily available at all times within the facility. EVACUATION DIAGRAMS: The fire evacuation diagrams lacked the location and number of resident sleeping rooms, the location of adjacent smoke compartments or refuge areas, the location of special locking or egress control arrangements, and did not include the identification of the path of travel to adjacent smoke compartments or exits. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire and Smoke Emergency Procedures, undated, failed to include the following: The FSEP 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	{0 810}		

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{0 810}	Continued From page 5 evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. In the email received on September 8, 2025, LALD-C indicated residents receive the resident handbook upon admission and are able to participate in evacuation drills. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. In the email received on September 8, 2025, LALD-C indicated staff receive emergency training through a third-party online platform and other staff meetings, but did not provide documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. 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 documentation, titled Fire Drill Report, undated, indicated evacuation drills were conducted on April 29, 2022, on the third shift and April 18, 2022, on the first shift. No other documentation was provided.	{0 810}		

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{0 810}	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 810}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study (BGS) requests to the Department of Human Services (DHS)) prior to staff providing services for all contracted temporary staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	{01290}		

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{01290}	Continued From page 7 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 5, 2026, at 8:40 a.m., unlicensed personnel (ULP)-M was observed providing assistance to multiple residents in the licensee's common area. ULP-M assisted residents with transfers, activities of daily living (ADLs), and providing transportation to the dining area. ULP-M was a temporary staff member hired by the licensee to provide services when licensee was unable to schedule their own employees for shifts. ULP-M had provided five (5) shifts which included provision of services to residents which included the shift on February 5, 2026. ULP-M's record lacked evidence of a cleared BGS from DHS's NetStudy 2.0 as required. On February 5, 2026, at 8:50 a.m., clinical nurse supervisor (CNS)-D stated ULP-M's record had been provided by the contracted temporary staffing agency. CNS-D stated licensee did not develop a completed record for any temporary staff and licensee had utilized multiple ULPs from the temporary staffing agency with similar employee records without a cleared BGS. CNS-D stated licensee would contact the temporary staffing agency and request the NetStudy 2.0 BGS. CNS-D stated the temporary staffing agency used a third-party BGS program and did not use the required DHS NetStudy 2.0 system. The licensee's 4.07 Temporary and Contracted Staff policy dated November 1, 2024, indicated each temporary or contract staff would have a	{01290}		

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{01290}	Continued From page 8 DHS BGS completed and included in their record. No further information provided.	{01290}		
{01350} SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for all temporary or contracted unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 5, 2026, at 8:40 a.m., unlicensed personnel (ULP)-M was observed providing assistance to multiple residents in the licensee's common area. ULP-M assisted residents with transfers, activities of daily living (ADLs), and providing transportation to the dining area.	{01350}		

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{01350}	Continued From page 9 ULP-M was a temporary staff member hired by the licensee to provide services when licensee was unable to schedule their own employees for shifts. ULP-M had provided five (5) shifts of services to residents which included the shift on February 5, 2026. ULP-M's record lacked evidence ULP-M completed the required orientation training to 144G statutes and lacked evidence ULP-M was orientated to each resident. On February 5, 2026, at 8:50 a.m., clinical nurse supervisor (CNS)-D stated ULP-M's record had been provided by the contracted temporary staffing agency. CNS-D stated licensee did not develop a completed record for any temporary staff and licensee had utilized multiple ULPs from the temporary staffing agency with similar employee records without all the required orientation. CNS-D stated the licensee would contact the temporary staffing agency and request training records for any temporary staff in order for the licensee to provide any required orientation the temporary staff did not receive. The licensee's 4.07 Temporary and Contracted Staff policy dated November 1, 2024, indicated each temporary or contract staff would be trained and orientated as if they were staff of the licensee. No further information provided.	{01350}		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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01500	Continued From page 10 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

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01500	Continued From page 11 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment, for one of two unlicensed personnel (ULP)-L. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-L was hired on December 18, 2007. ULP-L's undated My Transcript - [ULP-L's name] was identified by clinical nurse supervisor (CNS)-D as ULP-L's complete annual training. The transcript lacked evidence that ULP-L	01500		

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01500	Continued From page 12 completed any required annual training content in 2025. On February 5, 2026, at 9:00 a.m., CNS-D stated ULP-L had been assigned the required annual training content, but ULP-L lacked computer access at their home where staff do their annual online training. CNS-D stated the licensee would need to arrange for ULP-L to complete the annual training when they were in the facility instead. CNS-D stated the licensee was aware of the required content for all required annual training. The licensee's 5.06 Annual Required Staff Training policy dated November 1, 2024, indicated all required annual training content would be completed for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 13 (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 resident's service plans included all required content for three of three residents (R3, R5, and R11). 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: R3 R3 was admitted on July 1, 2022. R3's Service Plan created on July 1, 2022, lacked the schedule and methods of monitoring	01650		

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01650	Continued From page 14 assessments of the resident. R5 R5 was admitted on September 22, 2022. R5's Service Plan created on July 25, 2025, lacked the schedule and methods of monitoring assessments of the resident. R11 R11 was admitted on May 3, 2017. R11's Service Plan created on January 5, 2026, lacked the schedule and methods of monitoring assessments of the resident. On February 5, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-D stated the services plans for R3, R5, and R11 would need to have the schedule and method of monitoring assessments added. CNS-D stated the service plans for R3, R5, and R11 were templated the same as all other service plans for each resident. CNS-D stated a new service plan template would need to be created with the required content and new authentication from each resident would need to be obtained. The licensee's 6.08 Service Plan policy dated November 1, 2024, indicated the schedule and method of assessments would be included on each resident's service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01730	Continued From page 15	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that 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	01730		

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01730	Continued From page 16 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R5) who had a pen-based medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2026, at 10:50 a.m., the surveyor observed unlicensed personnel (ULP)-L administer R5's pen-based insulin without priming the insulin pen prior to administration. ULP-L removed the cap from R5's insulin pen, removed the cover from the needle, and attached the needle to the insulin pen. ULP-L dialed the insulin pen to eight (8) units, and then administered the insulin to R5. R5 was admitted on September 22, 2022.	01730		

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01730	Continued From page 17 R5's Service Plan created on July 25, 2025, read under the Medication Assistance section, "Medical assistance includes monitoring, reminders and administration by trained staff. Medication ordering, set up, storage and record keeping are included. Additional fee for complex medication issues, injections, syringe setup, controlled medications, and administration of prescription eye drops. Client requires staff to monitor Diabetes and to administer Insulin Injections." R5's Medication Information as of January 12, 2026, included three (3) medications which had a pen-based administration. The orders for the 3 medications read: - "Humalog Kwikpen 100 units/ml [milliliter] Pen. Inject 8 units under the skin THREE [sic] times a day before meals. Hold of bood sugar is less than 70." - "Lantus 100 unit/ml Pen. Inject 12 units subcutaneously once per day **Notify [CNS (clinical nurse supervisor)-D] or [licensee's LPN (licensed practical nurse) name] when Pen is at 100 units remaining**" - "Ozempic 1 mg [milligram] dose Pen. Inject 1 mg. subcutaneously every 7 [seven] days. For diabetes control." On February 4, 2026, at 11:00 a.m., ULP-L stated ULPs are not trained to prime pen-based medications. ULP-L stated there were no instructions about priming pen-based medications in any resident's record who had pen-based medications. The surveyor and ULP-L reviewed R5's pen-based medications in the licensee's electronic health record (EHR) and no instructions for priming pen-based medications were noted. During the review, licensed assisted living director (LALD)-A arrived in the medication	01730		

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01730	Continued From page 18 room and reviewed R5's record with ULP-L and the surveyor. LALD-A stated instructions would be included in R5's EHR if they were placed by the nurse who entered the orders into R5's record. On February 4, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-D stated licensee would need to audit each resident's record who had any pen-based medications as no priming instructions had been entered for any resident. CNS-D stated the licensee would need to review each pen-based medication's manufacturer's instructions and place the appropriate priming dose in the corresponding order for ULPs to administer. The licensee's 7.03 Medication Management Individualized Plan policy dated November 1, 2024, indicated each resident medication management record would include specific resident instructions related to the administration of medications. 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 and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 19 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R5) who had a pen-based medication. 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: MED ERROR On February 4, 2026, at 10:50 a.m., the surveyor observed unlicensed personnel (ULP)-L administer R5's pen-based insulin within priming the insulin pen prior to administration. ULP-L removed the cap from R5's insulin pen, removed the cover from the needle, and attached the needle to the insulin pen. ULP-L dialed the insulin pen to eight (8) units and then administered the insulin to R5. R5 was admitted on September 22, 2022.	01760		

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01760	Continued From page 20 R5's Service Plan created on July 25, 2025, read under the Medication Assistance section, "Medical assistance includes monitoring, reminders and administration by trained staff. Medication ordering, set up, storage and record keeping are included. Additional fee for complex medication issues, injections, syringe setup, controlled medications, and administration of prescription eye drops. Client requires staff to monitor Diabetes and to administer Insulin Injections." R5's Medication Information as of January 12, 2026, included three (3) medications which had a pen-based administration. The medication administration record (MAR) for the 3 medications read: -"Humalog Kwikpen 100 units/ml [milliliter] Pen. Inject 8 units under the skin THREE [sic] times a day before meals. Hold of bood sugar is less than 70." - "Lantus 100 unit/ml Pen. Inject 12 units subcutaneously once per day **Notify [CNS (clinical nurse supervisor)-D] or [licensee's LPN (licensed practical nurse) name] when Pen is at 100 units remaining**" - "Ozempic 1 mg [milligram] dose Pen. Inject 1 mg. subcutaneously every 7 [seven] days. For diabetes control." On February 4, 2026, at 11:00 a.m., ULP-L stated ULPs are not trained to prime R5's pen-based medications. ULP-L stated there were no instructions about priming pen-based medications in any resident's record who had pen-based medications. The surveyor and ULP-L reviewed R5's pen-based medications in the licensee's electronic health record (EHR) and no instructions for priming pen-based medications were noted.	01760		

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01760	Continued From page 21 On February 4, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-D stated licensee would need to audit each resident's record who had any pen-based medications as no priming instructions had been entered for any resident resulting in residents potentially not receiving the ordered dosage. CNS-D stated the licensee would need to review each pen-based medication's manufacturer's instructions and place the appropriate priming dose in the corresponding order for ULPs to administer. The Humalog instructions revised May 2025, read, "if you do not prime before each injection, you may get too much or too little insulin." The Lantus instructions revised May 2025, indicated the pen required two (2) units to be primed prior to administration of the medication. The Ozempic instructions dated October 2025, indicated the pen should be checked for flow on the first use only, but no priming for dosing after the initial check. The licensee's 7.03 Medication Management Individualized Plan policy dated November 1, 2024, indicated each resident medication management record would include specific resident instructions related to the administration of medications. The licensee's 7.24 Medication Error policy dated November 1, 2024, indicated medication errors would be documented, tracked, and data would be used for quality improvement. No further information was provided.	01760		

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01760	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident and documented those instructions in the resident's record for one of one resident (R11). 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	01950		

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01950	Continued From page 23 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: R11 was admitted on May 3, 2017. R11's Service Plan created on January 5, 2026, read under the Routine Delegated Medical Nursing Procedures section, "Belly wash with medicated treatment, assist with CPAP [continuous positive airway pressure], monitor oxygen, clean nebulizer." R11's Service Listing dated January 8, 2026, read under Routine Delegated Medical nursing or Therapy Proc (sic), "Oxygen Therapy: 3-5L [liters] from contractor when connected to BIPAP [bilevel positive airway pressure] machine maintaining SPO2 [peripheral capillary oxygen saturation] of 88% - 94%. Portable Bottles/concentrator to be set at 2L - 6L via Mask/Nasal Cannula as needed to Maintain O2 Saturation levels of 88% - 94% when not in bed using BIPAP. SPO2 readings to be taken 2x [times] per shift and PRN, Oxygen flow to be adjusted accordingly. Documentation to be completed under Therapy & Vital Signs." R11's untitled documented identified by clinical nurse supervisor (CNS)-D as screenshots from R11's administration record indicated the following: - January 25, 2026, at 3:03 p.m., Oxygen therapy/SP02% check at 70% - January 25, 2026, at 8:31 p.m., Oxygen therapy/SP02% check at 70% - January 29, 2026, at 9:00 a.m., Oxygen	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30328	A. BUILDING: _____ B. WING _____	R 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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01950	Continued From page 24 therapy/SP02% check at 79% - January 29, 2026, at 2:30 p.m., Oxygen therapy/SP02% check at 79% - February 1, 2026, at 12:02 p.m., Oxygen therapy/SP02% check at 82% - February 1, 2026, at 7:06 p.m., Oxygen therapy/SP02% check at 82% - February 2, 2026, at 6:49 p.m., Oxygen therapy/SP02% check at 85% - February 3, 2026, at 3:49 p.m., Oxygen therapy/SP02% check at 80% On February 5, 2026, at 10:20 a.m., CNS-D stated when unlicensed personnel (ULP) obtained a Sp02 which was out of the 88%-94% range, the ULP was to contact CNS-D or the on call nurse and document the actions taken to bring R11's SpO2 back into the therapeutic range. CNS-D stated they had revied R11's record on the times identified above that were out of range and found no documentation from the ULP on actions that were taken. CNS-D stated R11's EHR will be updated to require documentation when an ULP documents an SpO2 that is out of range. The licensee's 7.05 Treatment & Therapy Management Plan policy dated November 1, 2024, indicated resident specific documentation and monitoring of the treatment or therapy would be completed to prevent possible complications or adverse reactions. No further information would be provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 25	01960		
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 interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R11) who had an ordered treatment. 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: R11 was admitted on May 3, 2017. R11's Service Plan created on January 5, 2026, read under the Routine Delegated Medical	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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01960	Continued From page 26 Nursing Procedures section, "Belly wash with medicated treatment, assist with CPAP [continuous positive airway pressure], monitor oxygen, clean nebulizer." R11's Service Listing dated January 8, 2026, read under Routine Delegated Medical nursing or Therapy Proc (sic), "Oxygen Therapy: 3-5L [liters] from contractor when connected to BIPAP [bilevel positive airway pressure] machine maintaining SPO2 [peripheral capillary oxygen saturation] of 88% - 94%. Portable Bottles/concentrator to be set at 2L - 6L via Mask/Nasal Cannula as needed to Maintain O2 Saturation levels of 88% - 94% when not in bed using BIPAP. SPO2 readings to be taken 2x [times] per shift and PRN, Oxygen flow to be adjusted accordingly. Documentation to be completed under Therapy & Vital Signs." R11's untitled documented identified by clinical nurse supervisor (CNS)-D as screenshots from R11's administration record indicated the following: - January 25, 2026, at 3:03 p.m., Oxygen therapy/SP02% check at 70% - January 25, 2026, at 8:31 p.m., Oxygen therapy/SP02% check at 70% - January 29, 2026, at 9:00 a.m., Oxygen therapy/SP02% check at 79% - January 29, 2026, at 2:30 p.m., Oxygen therapy/SP02% check at 79% - February 1, 2026, at 12:02 p.m., Oxygen therapy/SP02% check at 82% - February 1, 2026, at 7:06 p.m., Oxygen therapy/SP02% check at 82% - February 2, 2026, at 6:49 p.m., Oxygen therapy/SP02% check at 85% - February 3, 2026, at 3:49 p.m., Oxygen therapy/SP02% check at 80%	01960		

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01960	Continued From page 27 On February 5, 2026, at 10:20 a.m., CNS-D stated when unlicensed personnel (ULP) obtained a Sp02 which was out of the 88%-94%, the ULP was to contact CNS-D or the on call nurse and document the actions taken to bring R11's SpO2 back into the therapeutic range. CNS-D stated they had reviewed R11's record on the times identified above that were out of range and found no documentation from the ULP on actions that were taken. CNS-D stated R11's EHR will be updated to require documentation when an ULP documents an SpO2 that is out of range. The licensee's 7.05 Treatment & Therapy Management Plan policy dated November 1, 2024, indicated resident specific documentation and monitoring of the treatment or therapy would be completed to prevent possible complications or adverse reactions. No further information would be provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an	{02040}		

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{02040}	Continued From page 28 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 19, 2025

Licensee
WESTWOOD PLACE, INC.
209 Jefferson Avenue Southwest
Watertown, MN 55388

RE: Conditional License Number 417362
Health Facility Identification Number (HFID) 30328
Project Number(s) SL30328016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 12, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the 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 under Minn. Stat. § 144G.20, Subd. 18.

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.

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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 and immediately correct any reissued orders 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. If you submit a request for a hearing, please specify whether you are appealing the order and

fines, the imposed conditions, or both.

CONDITIONAL LICENSE ISSUED:
MDH will issue WESTWOOD PLACE, INC. 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 WESTWOOD PLACE, INC. 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:** WESTWOOD PLACE, INC. will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. WESTWOOD PLACE, INC. must provide the Department:

   i. A list of the names and birthdates of any individuals WESTWOOD PLACE, INC. 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:** WESTWOOD PLACE, INC. will contract with an RN to provide consultation concerning all resident(s) to whom WESTWOOD PLACE, INC. provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from WESTWOOD PLACE, INC.. 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. The RN must not have any affiliation with WESTWOOD PLACE, INC. and MDH must review the RN's credentials and approve the selection. WESTWOOD PLACE, INC. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to WESTWOOD PLACE, INC. in an effort to help WESTWOOD PLACE, INC. 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. WESTWOOD PLACE, INC. 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 WESTWOOD PLACE, INC. 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 WESTWOOD PLACE, INC. to correct the violations cited during the survey as well as to determine the overall practice of WESTWOOD PLACE, INC. 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. Corrective Action Plan: WESTWOOD PLACE, INC. 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 WESTWOOD PLACE, INC. 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 WESTWOOD PLACE, INC. is in substantial compliance on the follow up survey, MDH will remove the conditions from WESTWOOD PLACE, INC.'s assisted living facility license, and WESTWOOD PLACE, INC. will correct any outstanding violations identified during the survey. If WESTWOOD PLACE, INC. 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. § 144G20, Subd. 14, a request for a hearing must be in writing and 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 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 submit a request for a hearing, please specify whether you are appealing the order 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 Kelly Thorson directly at: 320-223-7336 or email at: Kelly.Thorson@state.mn.us.

Sincerely,

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
	30328	A. BUILDING: _____ B. WING _____	09/12/2025

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30328016-0 On September 8, 2025, through September 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 27 residents; all of whom were receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on September 9, 2025, SL30328016, tag identification 1290. An immediate correction order was identified on September 10, 2025, SL30328016, tag identification 1750. An immediate correction order was identified on September 11, 2025, SL30328016, tag	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.	

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0 000	Continued From page 1 identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey conducted on March 8, 2022, through March 11, 2022. This practice resulted in a level one violation (a	0 345		

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0 345	Continued From page 2 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On September 8, 2025, at 3:00 p.m., licensed assisted living director (LALD)-D stated, "I have not been able to find that, maybe it is at home because it was important and I didn't want to lose it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
0 470 SS=F	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 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	0 470		

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	30328	A. BUILDING: _____ B. WING _____	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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0 470	Continued From page 3 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 and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 20 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2025, at 10:30 a.m., licensed assisted living director (LALD)-C stated they usually scheduled two unlicensed personnel (ULPs) on all three shifts, and one ULP that does a partial shift on both day and evening shift. On September 8, 2025, at 11:30 a.m., clinical	0 470		

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0 470	Continued From page 4 nurse supervisor (CNS)-D stated, "I don't have like a staffing plan that is written up I just go through what are needs are and get that many scheduled." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all	0 485		

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0 485	Continued From page 5 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2025, at 11:01 a.m., licensed assisted living director (LALD)-C was asked if the licensee was familiar with current minimum assisted living requirements. LALD-C stated, "Maybe, everything changes, I don't want to say yes and then realize I was saying yes to something I didn't know." The licensee's Assisted Living Contract that is used by all residents indicated, "Housing Related Services Included in the Monthly Rent [Licensee] includes all basic housing services or amenities identified below in the monthly rent. If Resident purchases or requires additional services after moving in, [Licensee] will charge an additional fee based on the agreed upon services. Such services are described in Sections 111-2 and IV below. Pricing for services not included in rent may be found on the attached pricing sheet a. Apartment Unit b. Availability of three (3) nutritious meals per day plus two (2) nutritious snacks ([Licensee] is able to accommodate the following specialized diets:	0 485		

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0 485	Continued From page 6 diabetic, gluten intolerant, high protein, low protein, low carbohydrate, low sodium, lactose intolerant, mechanical soft, soft food, thickened liquids, vegetarian, vitamin K restrictions) ([Licensee] (sic) diet may not be able to accommodate specialized diets other than those listed above)" the contract also indicated, "Housing Related Services Available Through [Licensee] at an Additional Fee [Licensee] is a licensed Assisting Living provider and will provide Resident with assisted living services on Provider's premises as needed at an additional charge to be discussed with Resident prior to initiating services. Services not included in the monthly rent but available from Provider for an additional charge include, but are not limited to, those items identified below. a. Assisted living services described below in Section IV, including non-emergency calls via the emergency call system b. Meal/Food Plan c. Guest meals d. Additional meals" The licensee's Assisted Living Contracts lacked an option for residents to opt out of payment for just one meal that residents would not want. On September 11, 2025, at 1:42 p.m., via email, license assisted living director (LALD)-C stated, "They (residents) have the options of picking their meals but it is a package deal. We were advised at our last survey, that regardless of what they opt for we are to have available three meals for our residents daily with snacks, we do not reimburse residents for meals they choose to decline. Food and help are already in place. Currently, the majority of our residents eat three meals with snacks daily."	0 485		

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0 485	Continued From page 7 The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights;	0 500		

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0 500	Continued From page 8 (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. 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: On September 8, 2025, at 9:34 a.m., the surveyor emailed the licensee that an onsite	0 500		

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0 500	Continued From page 9 assisted living facility survey would be initiated on September 8, 2025, at 10:30 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -conducting and handling background studies on employees; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -handling complaints regarding staff or services provided by staff; -conducting initial evaluations of residents' needs and the providers' ability to provide those services; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -orientation to and implementation of the assisted living bill of rights; -infection control practices; -reminders for medications, treatments, or exercises, if provided; -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; -medication and treatment management;	0 500		

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0 500	Continued From page 10 -delegation of tasks by registered nurses or licensed health professionals; -supervision of registered nurses and licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. On September 9, 2025, at 12:50 p.m., licensed assisted living director (LALD)-C stated, "All of our policies are from Care Providers, we bought it (a generic policy bundle) and they give you 30 days to take what you want and make it your own. Well, we didn't get it done in the time frame so we had to buy it again and we are going to be working on that soon." On September 10, 2025, at 12:38 p.m., clinical nurse supervisor (CNS)-D stated, "All of our policies are from Care Provider's, and we have not yet had time to modify them to make them facility specific. So, I can give you the generic policies that don't have our facility name or any of our specifics but that is all we would have." CNS-D and LALD-C indicated they have no awareness of, have not customized, implemented, trained employees, or maintained specific required policies. On September 11, 2025, at the time of exit, none of the above-mentioned facility specific policies had been provided. On September 12, 2025, at 11:05 a.m., the day after the conclusion of the survey CNS-D sent via email facility specific policies to cover the following topics; -orientation, training, and competency evaluations of staff, and a process for evaluating	0 500		

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0 500	Continued From page 11 staff performance; -conducting initial evaluations of residents' needs and the providers' ability to provide those services; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 12 by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control, by not cleaning shared equipment, and not performing appropriate hand hygiene, for one of three employees (unlicensed personnel (ULP)-J). This had the potential to affect all residents (R). 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: ULP-J began employment with the licensee and started providing assisted living services September 26, 2023. On September 9, 2025, at 8:33 a.m., the surveyor observed ULP-J entered the commons area and obtained vital signs for R9. ULP-J did not clean the vitals equipment after use. ULP-H then used the equipment to obtain vital signs for R10. ULP-G did not clean the equipment after use on R10 and put the equipment away. On September 9, 2025, at 8:45 a.m., ULP-H acknowledged the equipment was not cleaned after use and stated, "Well it should probably be cleaned after every use, to be honest they are not, and probably not cleaned often enough ever,	0 510		

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0 510	Continued From page 13 in fact we don't even have any wipes (disinfectant wipes) up here to clean them." On September 9, 2025, at 8:48 a.m., clinical nurse supervisor (CNS)-D brought ULP-H a container of disinfectant wipes and stated, "They are trained to clean them after every use, we will work on that." The surveyor requested but was not provided with a policy that identified when shared equipment would be cleaned. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to its grievance procedure, with all required content. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances. Upon entrance into the facility on September 8, 2025, at 10:30 a.m., the surveyor conducted a brief tour of the main entryway, common areas, hallway near the nursing and medication areas and hallway leading to the dining area and found no information of display informing about the licensee's grievance procedure near the main entrance or adjacent common areas. On September 9, 2025, at 12:30 p.m., LALD-C acknowledged they did not have the grievance procedure posted anywhere else and stated, "I can just make a copy and laminate it and stick it	0 550		

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0 550	Continued From page 15 to the window and I can do that with the rest of them if I need to and then it won't look like a home it will look like a facility but hey at least the state will be happy." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display its current assisted living license in the main entrance of the facility. This had the potential to affect all residents, staff and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at 10:30 a.m., the surveyor entered the facility and was not able to see the facility's current license posted. Licensed	0 570		

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0 570	Continued From page 16 assisted living director (LALD)-C showed surveyor the license displayed inside the main office near the entrance and acknowledged the horizontal blinds in the office window, which obscured the license from outside the office at the entry. On September 9, 2025, at 12:30 p.m., LALD-C acknowledged they did not have the license posted anywhere else and stated, "I can just make a copy and laminate it and stick it to the window and I can do that with the rest of them if I need to and then it won't look like a home it will look like a facility but hey at least the state will be happy." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced	0 580		

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0 580	Continued From page 17 by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. 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: The licensee failed to have documentation of a QMP. On September 8, 2025, at 11:33 a.m., licensed assisted living director (LALD)-C stated, "We don't do anything like a QAPI meeting, we only do staff meetings." The licensee's 2.31 Quality Management Project policy, dated August 1, 2021, indicated, "[Licensee] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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	30328	A. BUILDING: _____ B. WING _____	09/12/2025

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0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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: On September 9, 2025, at 12:45 p.m., the surveyor observed a community phone in the entrance room common areas. The surveyor	0 640		

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0 640	Continued From page 19 observed the facility's main entry area and common areas lacked the required posted information as follows: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility. On September 8, 2025, at 12:45 p.m., licensed assisted living director (LALD)-C stated, "Yep that's another of those postings you want us to have up there so I guess we will have to plaster the wall with postings, and it won't look like a home." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
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	0 650		

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0 650	Continued From page 20 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A and ULP-B, and contracted maintenance engineer (CME)-E) with employee records reviewed. 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: ULP-A ULP-A was hired on April 3, 2025, to perform direct care services to residents. On September 8, 2025, at 7:22 a.m. surveyor observed ULP-A assisting residents throughout the facility. ULP-A employee record lacked a job description.	0 650		

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0 650	Continued From page 21 ULP-B ULP-B was hired on August 24, 2025, to perform direct care services to residents. On September 9, 2025, at 2:00 p.m. surveyor observed ULP-B assisting residents throughout the facility. ULP-B employee record lacked a job description. CME-E CME-E was contracted to work for the licensee on an as needed basis for the past 14 years. Licensee was unable to locate the date contracted services began. On September 8, 2025, at 12:50 p.m., CME-E was observed working for the licensee and providing engineer staff with a tour of the facility. CME-E lacked an employee record. On September 9, 2025, at 12:38 p.m., licensed assisted living director (LALD)-C stated, "I don't have a start date for [CME-E], its 14 years ago he has been here for a long time, I have a file on him, but I looked for it and I can't seem to find it. I don't know where I put the job descriptions for staff right now, I will have to keep digging." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 22 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. 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:	0 660		

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0 660	Continued From page 23 On September 8, 2025, at 11:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated, "The last TB risk assessment was done in 2022 or 2023, I think. I have not done one since, it's on the list to do." The Licensee's 1.04 Infection Control policy dated August 1, 2021, read, "Your facility will complete a written community TB risk assessment and update the assessment annually per MDH guidelines. The assessment form was developed by the Minnesota Department of Health and is available for download at: https://www.health.state.rnn.us/diseases/tb/rules/riskwksht.docx." The Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019 dated May 16, 2019, indicated all health care personnel should have a baseline TB screening including an individual risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 24 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 have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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 25 The findings include: The licensee's EP plan dated September 9, 2025, after the start of survey, and August 10, 2023, lacked evidence of the following required content: -documentation of being reviewed annually; -documentation of the missing resident plan that must be reviewed quarterly; and -policies/procedures (P/P) to address arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents. On September 9, 2025, at 12:35 p.m., licensed assisted living director (LALD)-C acknowledged the EP plan was not all completed and there was missing items, and stated, "I am not going to give you the binder because I am trying to put it together for you. We don't have it all in one binder we have the information I am trying to make copies and put it together because we have the information all over the place." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	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	0 730		

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0 730	Continued From page 26 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, 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	0 730		

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0 730	Continued From page 27 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). 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 to the licensee on June 18, 2025, and discharged to family home on July 4, 2025. R1's record lacked a discharge summary that complied with part 4659.0120, subpart 9 to include: A. a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; and C. a reconciliation of all predischarge	0 730		

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0 730	Continued From page 28 medications with the resident's post discharge prescribed and over-the-counter medications. On September 10, 2025, at 8:50 a.m., clinical nurse supervisor (CNS)-D stated, "I don't have a discharge summary, we just write down when they discharge and where they are discharging to. I don't have a list of the exact medication disposition either, we write down the medications and RX number and quantity in this book when we dispose or donate medications, but we don't list whose meds are whose. It's how we do all the disposition." The licensee's 2.38 Resident Record - Information and Content policy, dated August 1, 2021, indicated resident records would include, "A discharge summary, including service termination notice and related documentation, when applicable" No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code (MSFC) in Minnesota Rules, chapter 7511. This had the potential to directly affect all	0 775		

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0 775	Continued From page 29 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C and contracted maintenance engineer (CME)-E. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE SPRINKLER SYSTEM MAINTENANCE The maintenance tag attached to the water based automatic fire sprinkler was last dated January 25, 2021. Water based automatic sprinkler systems are required to be inspected, tested, and maintained in accordance with MSFC Section 901 and National Fire Protection Association (NFPA) 25. LALD-C stated she did not know if the sprinkler system was inspected between 2021 and the date of the survey. On September 12, 2025, LALD-C emailed an inspection record for the sprinkler system dated September 10, 2025. FIRE RESISTANT RATED DOORS The fire-resistant rated doors in the following locations were provided with wood door wedge	0 775		

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0 775	Continued From page 30 hold open devises that prevented the doors from closing automatically. - The cross-corridor doors adjacent to the main entry and lounge. - The door from the lounge area to the hallway had a closer on it and was being propped open The fire-resistant rated doors in the following locations did not close and latch. - The 90 minute rated door to the dining room. - The 90 minute rated door between the 200 and 100 wings of the building. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with MSFC Section 1105. ELECTRICAL EXTENSION CORDS There were electrical extension cords used to supply power to the washer and dryer in the laundry room. One extension cord was wrapped around and hung from the gas supply line. There were electrical extension cords used to supply power to the large air conditioner units in the director's office, apartment 111, apartment 124, and apartment 126 Electrical extension cords shall not be used as permanent wiring and shall be used in accordance with MSFC Section 604. SMOKE ALARM MAINTENANCE The smoke alarm in apartment 107/106 fell apart when CME-E attempted to check the power supply and interconnection.	0 775		

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0 775	Continued From page 31 Smoke alarms shall be tested and maintained in accordance with the manufacturer's instructions. Smoke alarms shall be replaced when they fail to respond to operability tests, or when they exceed 10 years from the date of manufacture, unless an earlier replacement is specified in the manufacturer's published instructions in accordance with MSFC Section 907. EMERGENCY ILLUMINATION The emergency lights adjacent to apartments 202 and 214 did not turn on when tested. Emergency lighting shall be maintained in required spaces in accordance with MSFC Section 1008. These deficient conditions were visually verified at the time of discovery by LALD-C and CME-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not	0 780		

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WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 32 including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 780		

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0 780	Continued From page 33 On September 8, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C and contracted maintenance engineer (CME)-E. The surveyor asked CME-E to initiate a test of the smoke alarms in apartments 111/110 and 107/106. Upon testing, it was found that the smoke alarms were not interconnected. These deficient conditions were visually verified at the time of discovery by LALD-C and CME-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=C	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 had the potential to directly affect all residents, staff, and visitors.	0 790		

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0 790	Continued From page 34 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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 September 8, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C and contracted maintenance engineer (CME)-E. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. These deficient conditions were visually verified at the time of discovery by LALD-C and CME-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 35 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a	0 810		

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0 810	Continued From page 36 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, licensed assisted living director (LALD)-A emailed documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP was not located onsite in a central location where it was readily available at all times within the facility. EVACUATION DIAGRAMS: The fire evacuation diagrams lacked the location and number of resident sleeping rooms, the location of adjacent smoke compartments or refuge areas, the location of special locking or egress control arrangements, and did not include the identification of the path of travel to adjacent smoke compartments or exits. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire and Smoke Emergency Procedures, undated, failed to include the following: The FSEP 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 the identification of any residents that needed	0 810		

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0 810	Continued From page 37 assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. In the email received on September 8, 2025, LALD-C indicated residents receive the resident handbook upon admission and are able to participate in evacuation drills. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. In the email received on September 8, 2025, LALD-C indicated staff receive emergency training through a third-party online platform and other staff meetings, but did not provide documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. 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 documentation, titled Fire Drill Report, undated, indicated evacuation drills were conducted on April 29, 2022, on the third shift and April 18, 2022, on the first shift. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 38 (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060		

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01060	Continued From page 39 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 was admitted to the licensee and began receiving assisted living services on June 30, 2022. R4's signed Service Plan, dated November 20, 2024, indicated R4 received services including assistance with laundry, vitals, housekeeping, dressing, grooming, bathing, and medication	01060		

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01060	Continued From page 40 administration. R4's Charting notes indicated R4 was hospitalized from June 14, 2025, through June 18, 2025. R4's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On September 10, 2025, at 12:47 p.m., clinical nurse supervisor acknowledged there were no emergency relocation forms done for any residents and stated, "Nope, didn't even know that was something we needed." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for four of thirty-four staff, unlicensed personnel ((ULP)-B, ULP-F), server (S)-G, and cotracted maintenance engineer (CME)-E. 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 the potential to affect a large portion or all the residents). The findings include: On September 9, 2025, at 8:00 a.m., licensed assisted living director (LALD)-C provided the surveyor with the licensee's NETStudy 2.0 roster. ULP-B ULP-B was hired on August 24, 2025, to perform direct care services to the licensee's residents. ULP-B's employee record lacked evidence of a cleared background study as required. ULP-F ULP-F was hired on May 19, 2025, to perform	01290		

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01290	Continued From page 42 direct care services to the licensee's residents. ULP-F's employee record lacked evidence of a cleared background study as required. S-G S-G was hired on August 20, 2024, to perform direct care services to the licensee's residents. S-G's employee record lacked evidence of a cleared background study as required. CME-E CME-E was contracted to perform maintenance services to the licensee's facility for the past fourteen years. CME-E's employee record lacked evidence of a cleared background study as required. On September 9, 2025, at 10:40 a.m., LALD-C stated, "[CME-E] is an independent contractor we have a file on him but he is not on the roster he has been here for a long time. We usually run background studies on contracted staff. [ULP-B] we don't have one, she came over from [an agency company] so I knew she had a clean record. [ULP-F] she left and came back within 90 days, I guess I didn't know she was discharged off the record I thought if they worked within 90 days they did not need to be rerun. [S-G] we missed hers." On September 9, 2025, at 12:38 p.m., LALD-C stated, "I don't have a start date for [CME-E], its 14 years ago he has been here for a long time, I have a file on him but I looked for it and I cant seem to find it."	01290		

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01290	Continued From page 43 On September 9, 2025, at 11:51 a.m., via email, and at 12:48 p.m., in person, surveyor requested the licensee's policy on background studies. No policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for one of one unlicensed personnel (ULP-I) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2025, at 10:50 a.m. licensed assisted living	01350		

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01350	Continued From page 44 director (LALD)-C confirmed the licensee was utilizing contracted ULP's to maintain staffing for the facility. ULP-I was contracted on September 1, 2025, September 2, 2025, and September 6, 2025, to provide direct care services to the licensee's residents. The licensee lacked evidence of an employee file for ULP-I and lacked evidence of any orientation training for ULP-I. On September 10, 2025, at 9:00 a.m., during an interview with clinical nurse supervisor (CNS)-D and LALD-C, CNS-D acknowledged the licensee did not have an employee file on ULP-I or any contracted staff. When asked how the licensee trains contract staff CNS-D stated, "We don't they come in trained, they are assumed to be trained and able to work." CNS-D and LALD-C were informed that contract staff do require certain orientation training by the licensee and LALD-C stated, "Well then, we will be better off not hiring agency and just working ourselves or working short." On September 10, 2025, at 11:00 a.m., CNS-D stated, "[ULP-I] does not do meds we don't let agency staff do meds." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed	01420		

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01420	Continued From page 45 personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented instructions for a delegated task in the resident's record for one of one resident (R3) with catheter maintenance. 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: R3 admitted to the licensee and began receiving assisted living services on July 1, 2022.	01420		

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01420	Continued From page 46 R3's Service Plan Detail signed September 1, 2024, indicated R3 received assistance with grooming, activities, bathing, dressing, meal assistance, and housekeeping. The service plan indicated R3 also received the facility base package. R3's unsigned and undated Treatment Information form, indicated R3 received assistance with catheter cares, wound care, and oxygen. On September 10, 2025, at 7:15 a.m., the surveyor observed ULP-K provide assistance with changing the catheter overnight bag to a daytime leg bag and cleaning of overnight bag with a vinegar and water solution for R3. R3's treatment plan and electronic treatment administration record (emar) lacked documented instructions for when to update a nurse for catheter cares, wound care, and oxygen. On September 10, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-D stated, "We don't have that anywhere for them to read but they are all trained to contact the nurse if something is off." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440		

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01440	Continued From page 47 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01440		

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01440	Continued From page 48 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on April 3, 2025, to provide direct care services to residents. On September 8, 2025, at 7:22 a.m. surveyor observed ULP-A assisting residents throughout the facility. ULP-A's record lacked evidence a RN conducted direct supervision of ULP-A within 30 days of performing delegated tasks. On September 10, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-D acknowledged they had no 30-day supervisions done for staff and stated, "Yeah, we are still working on doing those." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as	01460		

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01460	Continued From page 49 provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for one of one employee (unlicensed personnel (ULP)-I) with employee records reviewed. 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	01460		

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01460	Continued From page 50 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2025, at 10:50 a.m. licensed assisted living director (LALD)-C confirmed the licensee was utilizing contracted ULP's to maintain staffing for the facility. ULP-I was contracted on September 1, 2025, September 2, 2025, and September 6, 2025, to provide direct care services to the licensee's residents. ULP-I employee record lacked evidence ULP-I received orientation to the following required topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Orientation to each specific resident and services provided.	01460		

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01460	Continued From page 51 On September 10, 2025, at 9:00 a.m., during an interview with clinical nurse supervisor (CNS)-D and LALD-C, CNS-D acknowledged the licensee did not have an employee file on ULP-I or any contracted staff. When asked how the licensee trains contract staff CNS-D stated, "We don't they come in trained, they are assumed to be trained and able to work." CNS-D and LALD-C were informed that contract staff do require certain orientation training by the licensee and LALD-C stated, "Well then, we will be better off not hiring agency and just working ourselves or working short." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning	01470		

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01470	Continued From page 52 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for two of two employees (unlicensed personnel (ULP)-A and ULP-B) with employee records reviewed. 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: ULP-A ULP-A was hired on April 3, 2025, to perform direct care services to residents. On September 8, 2025, at 7:22 a.m. surveyor observed ULP-A assisting residents throughout the facility. ULP-A employee record lacked evidence ULP-A received orientation to the following required topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Reporting maltreatment of vulnerable adults or minors; -Handing of resident complaints, reporting of	01470		

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01470	Continued From page 54 complaints, where to report; -Consumer advocacy services; and -Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-B ULP-B was hired on August 24, 2025, to perform direct care services to the licensee's residents. On September 9, 2025, at 2:00 p.m. surveyor observed ULP-B assisting residents throughout the facility. ULP-B employee record lacked evidence ULP-B received orientation to the following required topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; and -Review of types of Assisted Living services the employee will provide and provider's scope of license. On September 9, 2025, at 1:35 p.m., clinical nurse supervisor stated, "That's all we have for [ULP-B] but when she comes in at two, I will get her started filling out all the training paperwork. We will need to audit all the staff and get the trainings scheduled for each person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01540	Continued From page 55	01540		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-A and ULP-I) received the required amount of mental illness and de-escalation training within the required time frame. 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	01540		

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01540	Continued From page 56 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: The facility held an assisted living with dementia care license effective August 1, 2021. During the entrance conference on September 8, 2025, at 10:50 a.m., licensed assisted living director (LALD)-D stated they were aware of the contents of the employee record. ULP-A ULP-A was hired on April 3, 2025, to provide direct care services to residents. ULP-A's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. ULP-I ULP-I was contracted on September 1, 2025, September 2, 2025, and September 6, 2025, to provide direct care services to residents. ULP-I's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. On September 9, 2025, at 1:35 p.m., clinical nurse supervisor stated, "We will need to audit all the staff and get the trainings scheduled for each person."	01540		

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01540	Continued From page 57 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered 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.	01620		

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01620	Continued From page 58 (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	01620		

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01620	Continued From page 59 R3 admitted to the licensee and began receiving assisted living services on July 1, 2022. R3's diagnoses included dementia and hypertension. R3's Service Plan Detail signed September 1, 2024, indicated R3 received assistance with grooming, activities, bathing, dressing, meal assistance, and housekeeping. The service plan indicated R3 also received the facility base package. On September 10, 2025, at 7:15 a.m., the surveyor observed ULP-K provide assistance with changing the catheter overnight bag to a daytime leg bag and cleaning of overnight bag with a vinegar and water solution for R3. R3's 90-day reassessment titled General Assessment, dated June 17, 2025 lacked areas required on the uniform assessment tool including sleep preferences, health care directive, transportation, review of diagnoses, housekeeping/laundry, review of allergies, review of medications, review of emergency room visits, dental visits, and doctors' visits in the last 12 months, physical therapy and occupational therapy reports (if applicable, vital signs, weight, mental health status, speech, pain, treatments, risk indicators, decision maker, and follow up needs (if needed). On September 9, 2025, at 2:51 p.m., clinical nurse supervisor (CNS)-D stated, "All of our assessments are the same, even the initial assessments are the same as the general, we review the medications once a year in a bigger	01620		

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01620	Continued From page 60 assessment, but if we are missing items in the general assessment, we are missing them in all the assessments. This is why we are glad you are here so we can learn what we need to do differently." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about	01690		

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WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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01690	Continued From page 61 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). 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 September 8, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided medication management services to residents at the facility. The licensee's provided policies lacked: - requesting and receiving prescriptions for medications; - preparing and giving medications; - verifying that prescription drugs are administered as prescribed;	01690		

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01690	Continued From page 62 - documenting medication management activities; - controlling and storing medications; - monitoring and evaluating medication use; - resolving medication errors; - communicating with the prescriber, pharmacist, and resident and legal and designated representatives; - disposing of unused medications; - educating residents and legal and designated representatives about medications; and - how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. On September 9, 2025, at 12:50 p.m., licensed assisted living director (LALD)-C stated, "All of our policies are from Care Providers, we bought it (a generic policy bundle) and they give you 30 days to take what you want and make it your own. Well, we didn't get it done in the time frame so we had to buy it again and we are going to be working on that soon." On September 10, 2025, at 12:38 p.m., clinical nurse supervisor (CNS)-D stated, "All of our policies are from Care Provider's, and we have not yet had time to modify them to make them facility specific. So, I can give you the generic policies that don't have our facility name or any of our specifics but that is all we would have." CNS-D and LALD-C indicated they have no awareness of, have not customized, implemented, trained employees, or maintained specific required policies.	01690		

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01690	Continued From page 63 On September 11, 2025, at the time of exit, none of the above-mentioned facility specific policies had been provided. On September 12, 2025, at 11:05 a.m., the day after the conclusion of the survey CNS-D sent via email facility specific policies to cover the following topics; - preparing and giving medications; - documenting medication management activities; - controlling and storing medications; and - disposing of unused medications. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to	01750		

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01750	Continued From page 64 delegating the task of medication administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident (R) and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for two of two employees (ULP-A and ULP-B). 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: ULP-A ULP-A was hired on April 3, 2025, to perform direct care services to the licensee's residents. On September 8, 2025, at 7:22 a.m. surveyor observed ULP-A assisting residents throughout the facility. On September 9, 2025, at 11:04 a.m., clinical nurse supervisor (CNS-D) provided surveyor a master schedule indicating a two week rotating schedule. The schedule indicated ULP-A would be the medication administrator every other Saturday and Sunday. R3's electronic medication administration record (EMAR) indicated ULP-A administered medications to R3 on September 7, 2025.	01750		

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01750	Continued From page 65 ULP-B ULP-B was hired on August 24, 2025, to perform direct care services to the licensee's residents. On September 9, 2025, at 2:00 p.m. surveyor observed ULP-B assisting residents throughout the facility. R3's EMAR indicated ULP-B administered medications to R3 on September 5, 2025. The licensee lacked any competency records for ULP-A and ULP-B. On September 8, 2025, at 11:25 a.m., CNS-D stated, "I have it in place to start doing that at the end of this month, but so far no, we do not do any competency training for medications or treatments. I have [ULP-H] do all the training because she is really good at it, but at the end of the month I will do like a skills training and that is when competencies will get done for everyone." On September 10, 2025, at 12:38 p.m., surveyor requested the licensee's policy for delegation of medications. CNS-D indicated that all the policies were from Care Provider's (an outside agency) and that the licensee had not had time to modify them to make them facility specific. On September 10, 2025, at 1:32 p.m., CNS-D provided surveyor with a generic undated 5.01 Medication Management Services Provided by Unlicensed Personnel policy that indicated, "Medication Management Services provided by an Unlicensed Personnel to home care clients of [Name of company] will be performed consistent with Minnesota Comprehensive Home Care Rules, including prior training and competency	01750		

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01750	Continued From page 66 testing and the clients' individualized medication management plan(sic)" No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at 2:35 p.m., the surveyor observed the door to the medication room to be unsecured. Located in the unsecured medication room was two locked medication	01880		

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01880	Continued From page 67 carts and a medication mini refrigerator that did not have a locking mechanism. Located in the unlocked medication refrigerator were medication for 11 residents. On September 8, 2025, at 2:37 p.m., clinical nurse supervisor (CNS)-D acknowledged the door to the medication room had been left unlocked and there was no lock on the medication refrigerator and stated, ""Yeah, I will get a lock ordered for the fridge." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	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	01910		

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01910	Continued From page 68 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to 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 for one of one discharged resident (R1). 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: R1 was admitted to the licensee and began receiving services on June 18, 2025. R1 discharged to another facility on July 4, 2025. R1's record lacked a medication disposition to include 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 On September 10, 2025, at 8:50 a.m., clinical	01910		

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01910	Continued From page 69 nurse supervisor (CNS)-D stated, "I don't have a discharge summary, we just write down when they discharge and where they are discharging to. I don't have a list of the exact medication disposition either, we write down the medications and RX number and quantity in this book when we dispose or donate medications, but we don't list whose meds are whose. It's how we do all the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by:	01930		

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01930	Continued From page 70 Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. 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 September 8, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-D confirmed the licensee provided treatment management services. A request was made to review the licensee's policies and procedures. The licensee lacked treatment or therapy management policies and procedures that were facility specific, to include the following required topics: - requesting and receiving orders or prescriptions for treatments or therapies; - providing the treatment or therapy; - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On September 9, 2025, at 12:50 p.m., licensed	01930		

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01930	Continued From page 71 assisted living director (LALD)-C stated, "All of our policies are from Care Providers, we bought it (a generic policy bundle) and they give you 30 days to take what you want and make it your own. Well, we didn't get it done in the time frame so we had to buy it again and we are going to be working on that soon." On September 10, 2025, at 12:38 p.m., clinical nurse supervisor (CNS)-D stated, "All of our policies are from Care Provider's, and we have not yet had time to modify them to make them facility specific. So, I can give you the generic policies that don't have our facility name or any of our specifics but that is all we would have." CNS-D and LALD-C indicated they have no awareness of, have not customized, implemented, trained employees, or maintained specific required policies. On September 11, 2025, at the time of exit, none of the above-mentioned facility specific policies had been provided. On September 12, 2025, at 11:05 a.m., the day after the conclusion of the survey CNS-D sent via email facility specific policies to cover the following topics; - documenting treatment or therapy activities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 72 An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to conduct a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, licensed assisted living director (LALD)-C provided documents on the	02040		

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02040	Continued From page 73 hazard vulnerability assessment (HVA). The licensee's HVA, titled "7.02", dated September 8, 2025, failed to include the following: The HVA included the identification of global risk factors like severe weather, wild fires, epidemics, systems failures, and civil disturbances but failed to identify any potential hazards or risks that were specific to the facility's neighborhood, grounds, building, or population. The HVA did not include a section that identified specific mitigation factors to be in place for any hazards or risks that were identified in the HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=L	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, medical or nursing standards for one of one residents (R4) with hospital-style bed rails. This practice resulted in a level four violation (a violation that harmed a resident ' s health or	02310		

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02310	Continued From page 74 safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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: R4 R4 admitted to the licensee and began receiving services on June 30, 2022. R4 had diagnoses to include chronic obstructive pulmonary disease. R4's signed Service Plan, dated November 20, 2024, indicated R4 received assistance with bathing assistance, dressing, grooming, housekeeping, laundry, medication administration, nail care, and weekly vitals. On September 8, 2025, at 1:37 p.m., surveyor observed R4's bed had bilateral (two sides) half rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. On September 11, 2025, at 8:16 a.m., R4 stated, "I use them all the time when I am in bed." R4's record lacked; - Measurements - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines;	02310		

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02310	Continued From page 75 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. On September 10, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-D indicated there was no bedrail assessment completed for R4 and stated, "I don't have one." The surveyor then inquired if there would be bedrail assessments for any other resident in the facility with bedrails and the CNS stated, "Nope because I didn't know I needed to do one." On September 11, 2025, at 9:08 a.m., CNS-D provided surveyor with a generic undated 4.19 Siderails policy that indicated, "It is the policy of [Name of company] to limit the use of medical devices to those that are considered "safe", based on current standards of practice. When [Name of company] is aware a home care client is utilizing siderails (a medical device) on. a bed, [Name of company] shall assess the use, educate the client, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the siderail." On September 11, 2025, at 9:14 a. m., CNS-D stated, "As far as the bedrails go I didn't know I needed to do anything when they get a hospital bed that comes with rails, typically all the hospital beds that are rented come with the bedrails attached." The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30328	A. BUILDING: _____ B. WING _____	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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
02310	Continued From page 76 April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "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." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30328	A. BUILDING: _____ B. WING _____	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

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02310	Continued From page 77 being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - 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; - 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". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Food & Beverage Inspection Report

Establishment Info

WESTWOOD PLACE INC
209 JEFFERSON AVENUE SW
Watertown, MN 55388
Carver County
Parcel:

Phone:

License Info

License: HFID 30328

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8087251107
Inspection Type: Full - Single
Date: 9/9/2025 Time: 3:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH LALD, OWNER JOY GORRA.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO HRD NURSE SURVEYOR.

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

I acknowledge receipt of the Metro District Office inspection report number F8087251107 from 9/9/2025

John Boettcher

JOY GORRA
LALD, OWNER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

WESTWOOD PLACE INC
Watertown
County/Group: Carver County

Inspection Info

Report Number: F8087251107
Inspection Type: Full
Date: 9/9/2025
Time: 3:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

WESTWOOD PLACE INC
Watertown
County/Group: Carver County

Inspection Info

Report Number: F8087251107
Inspection Type: Full
Date: 9/9/2025
Time: 3:00:00 PM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 50 PPM
Comment:
Violation Issued?: No