



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 4, 2025

Licensee
People Incorporated DSL
726 Northeast 2nd Street
Minneapolis, MN 55413

RE: Project Number(s) SL30393016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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 within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

People Incorporated DSL

June 4, 2025

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER PEOPLE INCORPORATED - DSL			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NE 2ND STREET MINNEAPOLIS, MN 55413		
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: Project # SL30393016 On April 21, 2025, through April 24, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were twelve (12) residents receiving services under the Assisted Living License.	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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 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 interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required. 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	0 470			

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0 470	Continued From page 2 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 develop and implement a staffing plan for determining its staffing level based on the following: - includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - 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 -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. On April 23, 2025, at 12:23 p.m., director of operations (DOO)-F stated, "we do not have a staffing plan that is reviewed twice a year with nursing'. DOO-F stated the licensee created the master staffing schedule, but they were not aware of the required staffing plan to address the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 3 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current 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	0 680			

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0 680	Continued From page 4 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: The licensee's Emergency Procedures revised February 2023, lacked the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - a communication plan that included: - arrangement with other facilities - names and contact information for resident physicians - contact information for federal, state, tribal, local EP staff, or the ombudsman - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. On April 23, 2025, at 1:00 p.m., licensed assisted living director (LALD)-D acknowledged the provided EP plan was missing customizations for	0 680			

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0 680	Continued From page 5 the licensee. LALD-D stated the information provided regarding the emergency preparedness plan was everything the licensee had. The Licensee Assisted Living Emergency Preparedness Plan - Appendix Z Compliance dated September 2022, indicated "[Licensee] emergency preparedness will include all the required elements of Appendix Z." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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 in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 775			

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0 775	Continued From page 6 The findings include: On April 22, 2025, from 1:00 p.m. to 2:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and lead facilities tech (LFT)-F. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS: 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. The doors in the following locations did not close and latch. - The stairwell door by apartment 302 was held open by the flooring on the stair landing. - The stairwell door by apartment 301 was held open by the flooring on the stair landing. - The stairwell door adjacent to apartment 203. - The door to apartment 302. - The two rated doors on the main level on each side of bathroom 2. These deficient conditions were visually verified at the time of discovery by LALD-D and LFT-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

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0 810	Continued From page 7 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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 two violation (a violation that did not harm a resident's health or	0 810			

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0 810	Continued From page 8 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 22, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Annex J: Fire Policy & Procedure, undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include 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. On April 22, 2025, at 3:30 p.m., LALD-D stated	0 810			

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0 810	Continued From page 9 they did not have a policy section specifically for resident actions and did not have a system in place to identify residents that need assistance in a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, Staff Meeting Agenda, dated July 24, 2024, September 11, 2024, and October 9, 2024 indicated staff reviewed the emergency preparedness procedures and fire drill reports at staff meetings. The signed attendance sheets indicated that each meeting had nine attendees, four attendees, and three attendees respectively. LALD-D lacked documentation to indicate all employees received the required training on the FSEP. On April 22, 2025, at 3:30 p.m., LALD-D stated they did not have any additional training documentation, but stated staff that missed the staff meetings were expected to watch the recording. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, Assisted Living Fire Drill Report and Bomb Drill Report, indicated evacuation drills were conducted on March 15, 2024, April 12, 2024, May 17, 2024, June 17, 2024, September 11, 2024, October 16, 2024, December 30, 2024, March 11, 2025 and April 20, 2025. Only two Fire Drill Reports included information about the time of day the drill was completed. No other documentation was provided.	0 810			

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0 810	Continued From page 10 On April 22, 2025, at 3:30 p.m., LALD-D stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060			

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01060	Continued From page 11 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted on June 13, 2023. R1's Service Plan dated February 11, 2025, indicated R2 received services including assistance with medication administration.	01060			

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01060	Continued From page 12 R1's Progress Notes, dated from January 24, 2025, to February 4, 2025, indicated R1 was hospitalized from January 24, 2025, and returned from hospital on February 4, 2025. R1's record lacked a written notice that contains, at a minimum: - notification to the Office of Ombudsman for Long-Term Care with in four days that R1 had been relocated and had not returned to the facility. On April 23, 2025, at 1:10 p.m., legal and compliance (LC)-G acknowledged R1's record was missing notification to the Office of Ombudsman for Long-Term Care with in four days that R1 had not returned to the facility. LC-G stated they were aware of the required content for an emergency relocation, but they didn't consider hospitalization emergency relocation. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060			
01470 SS=D	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	01470			

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

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01470	Continued From page 14 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include the required content for one of two employees (registered nurse (RN)-C). 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: RN-C had a hire date of March 4, 2024, to provide direct care services to the licensee's residents. RN-C's record lacked the following required content: - handling of emergencies and use of emergency services. On April 24, 2025, at 1:13 p.m. legal and compliance (LC)-G stated the licensee completed orientation training for staff on the orientation	01470			

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01470	Continued From page 15 requirements, but LC-G acknowledged RN-C's record was missing handling of emergencies and use of emergency services training. Also, LC-G stated, "We do not discuss using emergency services". The licensee's Assisted Living Staff Orientation Policy date revised September 2022 indicated "All staff of [licensee] Assisted Living facilities who provide and supervise direct services must complete an orientation to assisted living facility licensing requirements and regulations including handling of emergencies and use of emergency services before providing assisted living services to clients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
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: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650			

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01650	Continued From page 16 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or the resident's representative to document agreement on the services to be provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on June 13, 2023. R1's Service Plan dated February 11, 2025,	01650			

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01650	Continued From page 17 indicated R1 received services to include medication administration. R2 R2 was admitted to the licensee on November 13, 2012. R2's Service Plan dated October 7,2024, indicated R2 received services to include medication set-up, and managing behaviors. R1 and R2's records lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee. During interview on April 23, 2025, at 1:30 p.m., legal and compliance (LC)-G, and licensed assisted living director (LALD)-D stated R1 and R2's service plans were not signed by the resident or resident's representatives. LALD-D stated they may have been an oversite and moving forward would make sure all the service plans are signed by the resident or resident's representative. The licensee's Assisted Living Service Plan Policy dated September 2022, indicated "The service plan and any revisions shall include a signature or other authentication by [licensee] and by the client, or client's representative, documenting agreement on the services to be provided." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650			

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02320	Continued From page 18	02320			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication set up for one of one unlicensed personnel (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's Service Plan dated October 7,2024, indicated R2 received services to include medication set-up and managing behaviors. On April 21, 2025, at 12:01 p.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated the licensee provided medication set up for the residents and ULPs were responsible to set up medications for residents. Also, CNS-A stated ULPs were trained to set up	02320			

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02320	Continued From page 19 medications for residents. On April 22, 2025, at 8:30 a.m., the surveyor observed ULP-B remind R2 to take her morning medication from a seven-day medication planner. When the surveyor asked ULP-B who set up the medications, ULP-B confirmed that she set up R2's weekly medications every Friday. Also, ULP-B stated they were trained to set up medications for residents. On April 24, 2024, at 1:24 p.m., CNS-A stated ULPs were responsible for medication set up once they have demonstrated competency to CNS. CNS-A stated, "This process is all about gaining independence with medication setup and administering their own medications as if they were on leave of absent (LOA) however still onsite". Minnesota statute 144G.08, subdivision 41 dated 2022, defined Medication setup as arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. The licensee Medication and Procedures manual policy dated January 19, 2024, indicated "All employees, including Program Managers, Supervisors, and Directors who provide Medication Administration, Medication Assistance, Medication Setup, Medication Packing, or Self-Administration of Medication to clients must successfully complete the Medication Administration training prior to providing any of these services. Proof of completion of the applicable training course is required to be recorded in Relias [electronic health record]."	02320			

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02320	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: 04/22/25
Time: 08:38:16
Report: 1018251075

Food and Beverage Establishment Inspection Report

Page 1

Location:

People Incorporated - Dsl
726 Ne 2nd Street
Minneapolis, MN55413
Hennepin County, 27

Establishment Info:

ID #: 0038471
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517740011
ID #:

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

No NEW orders were issued during this inspection.

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

ESTABLISHMENT DOES NOT COOK ANY FOOD FOR RESIDENTS. RESIDENTS DO ALL COOKING AND SHOPPING FOR THEMSELVES.

TWO MAIN KITCHENS FOR RESIDENT USE, THREE STUDIO APARTMENTS WITH THEIR OWN KITCHENS.

NO FOOD INSPECTION NECESSARY AS RESIDENTS ARE PREPARING ALL THEIR OWN FOOD.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018251075 of 04/22/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

FALON BOYD
MANAGER

Signed: _____

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us