



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 30, 2025

Licensee

The Fountains at Hosanna
9850 163rd Street West
Lakeville, MN 55044

RE: Project Number(s) SL29049016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 10, 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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

- Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT HOSANNA			STREET ADDRESS, CITY, STATE, ZIP CODE 9850 163RD STREET WEST LAKEVILLE, MN 55044		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL29049016-0 On December 8, 2025, through December 10, 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 101 residents; 78 receiving services under the Assisted Living Facility with Dementia Care license. On March 6, 2026, the survey results were ammended and Tag 0100 was removed after reviewing additional information provided by the facility.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag."The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
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 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of two employees (unlicensed personnel (ULP)-C and ULP-E). 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).	0 510			

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0 510	Continued From page 4 The findings include: On December 8, 2025, at 11:16 a.m., the surveyor observed ULP-C prepare to check R2's blood sugar. ULP-C stated R2 had a Libre Sensor (device that continuously monitors blood sugar); however, it had been giving inaccurate readings, so the ULP were manually checking R2's blood sugar via finger poke using the facility's glucometer. ULP-C gathered the facility glucometer, alcohol prep pad and lancet and went to R2's room and checked R2's blood sugar. ULP-C returned to the medication cart and placed the glucometer back in the medication cart drawer without disinfecting it. On December 9, 2025, at 6:54 a.m., the surveyor observed ULP-E check R1's blood sugar with the facility's glucometer. After checking R1's blood sugar, ULP-E returned to the medication cart, disposed of the test strip in the sharps container, remove gloves, documented R1's blood sugar results and place the facility glucometer back in the medication cart. ULP-E did not perform hand hygiene after she removed gloves and did not disinfect the glucometer after using it. On December 9, 2025, at 7:06 a.m., the surveyor observed ULP-E log into the electronic health record via laptop, put gloves on, remove medication cards from the drawer, compare each medication to the order in the medication administration record (MAR), punch each medication into a medication cup and gather R3's inhaler and nasal spray. ULP-E brought the medications to R3 who was sitting at the puzzle table. While administering R3's medications, ULP-E wiped her nose twice with her gloved hand. ULP-E then returned to the medication cart, removed the spacer from R3's inhaler and	0 510			

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0 510	Continued From page 5 brought the spacer into R2's room (different resident) to clean and wash it. After cleaning R3's spacer she returned to the medication cart, put the spacer away and then removed gloves. ULP-E documented R3's medication administration. ULP-E wore the same pair of gloves during the entire observation noted above and did not perform hand hygiene after removing gloves. On December 9, 2025, at 7:55 a.m., the surveyor observed ULP-E put gloves on, removed R1's medication cards from the medication cart, compare each medication to the order in the MAR, punch each medication into a medication cup. ULP-E wiped her nose with her gloves hand and then dumped the medications that were in the medication cup onto a Kleenex. ULP-E then used her gloved hand to count each medication and put them back into the medication cup. ULP-E then gathered R1's medications, insulin and laptop and brought them to R1's room. ULP-E prepared and administered R1's insulin then logged into the laptop to verify which site to place R1's patch on. ULP-E applied R1's patch to his left upper back and then removed the old patch and disposed of it. ULP-E then left R1's room to get a Kleenex, returned and administered R1's eye drops, assisted R1 to a sitting position, administered his oral medications and nasal spray. ULP-E returned to the medication cart, removed gloves, did not perform hand hygiene and documented medication administration on the laptop. ULP-E wore the same pair of gloves for the entire observation noted above. On December 10, 2025, at 10:06 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the staff to perform hand hygiene prior to applying gloves and again after gloves were	0 510			

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0 510	Continued From page 6 removed. ICNS-B further stated staff should change gloves between performing different tasks. The licensee's Gloves-Procedure for Using policy dated August 1, 2021, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, non-intact skin, secretions, feces, or a contaminated item or surface, such as soiled linens or wound dressing. Gloves will be removed carefully and disposed of in a proper container. The licensee's Disinfecting of Reusable Equipment and Surfaces policy dated August 1, 2021, indicated reusable equipment and environmental surfaces will be properly disinfected. Whenever possible, clients (residents) will have their own reusable equipment, and the equipment will not be shared with other clients or residents. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	0 700			

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0 700	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four residents' (R1) personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 9, 2025, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to administer medications to R1. ULP-E logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. ULP-E left R1's record open on the laptop screen which was visible to others. ULP-E returned to the medication cart, documented the administration of R1's medication and went to R2's room to remind him to go to breakfast. ULP-E left R1's record open on the laptop screen, which was visible to others. On December 9, 2025, at 8:30 a.m., ULP-E stated they were supposed to log off or close the laptop screen when not using it to protect resident information. On December 10, 2025, at 10:42 a.m., interim clinical nurse supervisor (ICNS)-B stated all staff were trained to keep resident records confidential	0 700			

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0 700	Continued From page 8 and private from any unauthorized individuals. The licensee's Client Record Confidentiality policy dated August 1, 2021, indicated client (resident) records and client information will be kept confidential. Access to paper and electronic client records will be limited to only the information needed by employees, contractors, other health care providers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a client ' s health or safety but had the potential to have harmed a client ' 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 clients).	0 775			

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0 775	Continued From page 9 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 11, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency training and evaluations were completed by one	01330			

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01330	Continued From page 10 of one volunteer (V)-F prior to providing direct cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 8, 2025, at 11:56 a.m., the surveyor observed V-F in the dining room feeding R5 her modified diet. -at 12:05 p.m., unlicensed personnel (ULP)-C stated V-F's grandmother resided at the facility and when V-F visited, she would also volunteer. ULP-C stated V-F frequently assisted residents in the dining room during mealtimes, including feeding R5. -at 12:20 p.m., V-F stated her grandmother resided at the facility. V-F stated she helped the staff with residents whenever she could during her visits with her grandmother. On December 9, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A stated V-F did not have scheduled volunteered hours unless it was for a planned event. The surveyor inquired if V-F had a employee record that included training. LALD-A provided the surveyor V-F's employee record which contained a volunteer application dated May 17, 2024, volunteer emergency medication information form, a background study clearance letter, and volunteer agreement dated May 17, 2024.	01330			

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NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT HOSANNA			STREET ADDRESS, CITY, STATE, ZIP CODE 9850 163RD STREET WEST LAKEVILLE, MN 55044		
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01330	Continued From page 11 On December 9, 2025, at 9:29 a.m., interim clinical nurse supervisor (ICNS)-B and regional nurse (RN)-H stated V-F was not trained or competency tested on delegated tasks which included modified diets or feeding assistance. RN-H stated V-F should not assist residents (outside of her own family member) with feeding as she had not been trained. RN-H stated the licensee had already sent a notification out to all volunteers clarifying that as volunteers they could not complete delegated tasks. ICNS-B stated the staff were also educated on this topic and to notify nursing if they have questions on what volunteers are able to do with residents. The licensee's Volunteer Onboarding policy dated August 2023, indicated persons who volunteer will go through an onboarding process. The procedure includes the following: 1. Potential volunteer submits an application 2. Volunteer/Active Living Coordinator schedules an interview with applicant 3. The Volunteer/Active Living Coordinator has the applicant sign off on the following onboarding forms, including but not limited to: Ebenezer Volunteer Agreement (if Handbook is not provided) and Ebenezer Volunteer Nondisclosure Agreement (if Handbook is not provided) 4. Volunteers are to be treated as ancillary employees for orientation, attending NEO (new employee orientation) Day 1 and Day 2 and completing dementia training. 5. Volunteers are oriented to the community and to the department/area in which they are volunteering. 6. All volunteers have a paper or electronic personnel file that is maintained by Volunteer Services. 7. Volunteers who volunteer ten (10) hours or	01330			

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01330	Continued From page 12 more per week are required to complete the TB Screening Tool for Health care workers process. 8. Background checks and TB screening forms are kept in a secure location in the Volunteer/Active Living Coordinator's Office at each site. The licensee's Orientation and Training: Employee policy dated January 1, 2025, indicated all staff providing and supervising direct services will complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01330			
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents for one of one volunteer (V-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01480			

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01480	Continued From page 13 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 was admitted on September 1, 2016, with diagnoses that included dementia. R5's service plan dated December 2, 2025, indicated R2 received assistance to include Dining: Feeding Assist and texture modified diet (resident is on mechanical soft diet with thin liquids). R5's Service Checkoff List dated December 2025, included the following: -Dietary: Texture Modified: Resident is on mechanical soft diet with thin liquids. Prepare food item per specialty diet requirements -Dining: Feeding Assist: Resident pockets foods. Encourage alternating solids and liquids. If pocketing, stop feeding and re-attempt later. No place mat- it is too distracting for her and then she won't eat. Unlicensed staff to physically assist resident to eat and drink meals supporting independence where possible. Staff to report any difficulty with swallowing, coughing or choking during meals. On December 8, 2025, at 11:56 a.m., the surveyor observed V-F in the dining room feeding R5 her modified diet. V-F's employee record lacked evidence of orientation to each specific resident and services provided.	01480			

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01480	Continued From page 14 On December 9, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A provided the surveyor V-F's employee record which did not contain any orientation or training documents. On December 9, 2025, at 9:29 a.m., interim clinical nurse supervisor (ICNS)-B and regional nurse (RN)-H stated V-F had not been trained or competency tested on any resident services or orientation to each specific resident and services provided. RN-H stated V-F was not trained because she should not have been providing services to any resident besides her own grandmother who resided at the facility. The licensee's Orientation and Training: Employee policy dated January 1, 2025, indicated all staff providing and supervising direct services will complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation to Assisted living would include: -oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01480			
01620 SS=E	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	01620			

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01620	Continued From page 15 initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	01620			

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01620	Continued From page 16 (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for four of four residents (R1, R2, R3 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 was admitted on March 12, 2023, with diagnoses that included diabetes R1's service plan dated December 2, 2025, indicated R1 received assistance with services to include grooming, dressing, bathing, safety checks, behavior management plan, modified diet, blood pressure monitoring, diabetic management and medication administration.	01620			

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01620	Continued From page 17 R1's ongoing nursing assessments dated May 16, 2025, August 18, 2025, and November 19, 2025, were reviewed. The August 18, 2025, assessment was completed 94 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on June 27, 2025, with diagnoses that included diabetes. R2's service plan dated July 11, 2025, indicated R2 received assistance with services to include grooming, dressing, bathing, transfers, bed mobility, ambulation, safety checks, behavior management plan, vital sign monitoring, diabetic management and medication administration. R2's ongoing nursing assessments dated June 27, 2025, July 7, 2025, July 11, 2025, and October 11, 2025, were reviewed. The October 11, 2025, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. R3 R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include grooming, dressing, bathing, toileting, bed mobility, transfer assist, modified diet, Velcro compression, Rooke boot, oxygen, and medication administration. R3's ongoing nursing assessments dated March 26, 2025, June 26, 2025, and September 25, 2025, were reviewed. The June 26, 2025, assessment was completed 92 days after the	01620			

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01620	Continued From page 18 date of the previous assessment and the September 25, 2025, assessment was completed 91 days after the date of the previous assessment, thus both exceeded 90 calendar days. R4 R4 was admitted on November 3, 2021, with diagnoses that included diabetes. R4's service plan dated April 6, 2025, indicated R4 received assistance with services to include bathing, diabetic management and medication administration. R4's ongoing nursing assessments dated June 4, 2025, September 2, 2025, and December 2, 2205, were reviewed. The December 2, 2025, assessment was completed 91 days after the previous assessment, thus exceeding 90 calendar days. On December 10, 2025, at 10:21 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the nurses to complete all assessments within the required time frame. ICNS-B stated she would review how to pull a report within their electronic health record system that provides due dates for all resident assessments with the nurses. The licensee's Assessments of Clients- Initial and Ongoing policy dated May 23, 2022, indicated resident reassessment and monitoring will be conducted no more than 14 calendar days after initiation of services. Ongoing client (resident) reassessment and monitoring will be conducted as needed, based on changes in the needs of the client (resident) and not to exceed 90 calendar days from the client's (resident's) last date of the	01620			

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01620	Continued From page 19 uniform assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that 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	01730			

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01730	Continued From page 20 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at approximately 9:45 a.m., interim clinical nurse supervisor (ICNS)-B stated resident medications were stored mainly in a medication cart; however, overflow medications were stored	01730			

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01730	Continued From page 21 in the nurse's office and medications requiring refrigeration were stored in a secured refrigerator. R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders included the following: -ammonium Lac-12% cream; apply one application topically to lower legs and feet twice daily, order dated January 27, 2025 -diclofenac sodium 1% gel; apply 4 grams topically to knees twice daily, order dated January 27, 2025 -SF 5000 Plus cream 1.1 %; small amount to brush teeth for two minutes twice a day and spit out, order dated January 27, 2025 -Nystatin powder 100,000 units; apply to reddened area of groin folds twice a day, order dated January 27, 2025 -Zinc Oxide 6% cream; apply one application to left groin and buttocks twice a day for skin irritation, order dated September 22, 2025 -miconazole 2% powder; apply topically to groin area twice daily, order dated March 25, 2025 On December 9, 2025, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R3. ULP-E stated the caregivers administered R3's topical medications which were stored in a locked cabinet in R3's room. R3's medication management plan dated September 25, 2025, included within the comprehensive assessment indicated the	01730			

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01730	Continued From page 22 following: -Medications are kept in a locked medication cart -Resident has controlled medications. Medications are secured with a double lock system R3's medication management plan did not include the locked cabinet in R3's room that stored his topical medications. On December 10, 2025, at 10:38 a.m., ICNS-B stated the licensee was in the process of updating medication management plans to reflect topical medications being stored in the resident's room for the caregivers to administer. The licensee's Medication Management Services policy dated August 1, 2021, indicated the RN will develop an individualized medication management plan for each client (resident) receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	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,	01750			

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01750	Continued From page 23 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 one of three unlicensed personnel (ULP-E) completed medication administration according to manufacturer instructions observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on March 12, 2023, with diagnoses that included diabetes R1's service plan dated December 2, 2025, indicated R1 received assistance with diabetic management and medication administration. R1's medication administration record (MAR) dated December 2025, included the following: -Lantus insulin, inject 18 units subcutaneously	01750			

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01750	Continued From page 24 once daily On December 9, 2025, at 7:55 a.m., the surveyor observed ULP-E prepare R1's Lantus insulin. ULP-E cleansed the back of R1's left arm with an alcohol prep pad, injected the insulin, then immediately removed the pen/needle from R1's arm once administered. R3 R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's medication administration record (MAR) dated December 2025, included the following: -albuterol 90 micrograms (mcg); inhale two puffs into the lungs twice daily -fluticasone spray 50 mcg; spray one spray in each nostril once daily On December 9, 2025, at 7:06 a.m., the surveyor observed ULP-E prepare R3's medications which included an albuterol inhaler and fluticasone nasal spray. ULP-E brought R3's medications, inhaler and nasal spray to R3 who was sitting at the puzzle table. ULP-E instructed R3 to open his mouth and ULP-E administered two puffs of the albuterol inhaler without waiting in between puffs. R3 did not inhale while the puffs were administered as ULP-E did not provide any instructions to him besides to open his mouth. ULP-E then administered one spray of fluticasone nasal spray into each nostril. R3 did not inhale with each spray as ULP-E did not provide any instruction to him.	01750			

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NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT HOSANNA			STREET ADDRESS, CITY, STATE, ZIP CODE 9850 163RD STREET WEST LAKEVILLE, MN 55044		
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01750	Continued From page 25 On December 10, 2025, at 10:19 a.m., interim clinical nurse supervisor (ICNS)-B stated expectation with insulin pen administration would be to hold the insulin pen against the skin for five to 10 seconds prior to removing the needle from the skin. ICNS-B stated she expected the ULP to provide instructions to the residents when they are administering inhalant medications and to wait one to two minutes between puffs. The Lantus SoloStar pen manufacturer's instructions dated 2022, indicated: Step 5. Inject your dose - Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) - Release the button and remove the needle from your skin. The albuterol inhaler manufacturer's instructions dated 1. Shake the inhaler well before each spray. Take the cap off the mouthpiece of the actuator. Look inside the mouthpiece for foreign objects and take out any you see. 2. Hold the inhaler with the mouthpiece down 3. Breath out through your mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close your lips around it 4. Push the top of the canister all the way down while you breathe in deeply and slowly through your mouth 5. After the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth 6. Hold your breath for about 10 seconds, or for	01750			

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01750	Continued From page 26 as long as is comfortable. Breathe out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait one minute and shake the inhaler again. Repeat steps two through six. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760			

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01760	Continued From page 27 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 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders included the following: -ammonium Lac-12% cream; apply one application topically to lower legs and feet twice daily, order dated January 27, 2025 -diclofenac sodium 1% gel; apply 4 grams topically to knees twice daily, order dated January 27, 2025 -SF 5000 Plus cream 1.1 %; small amount to brush teeth for two minutes twice a day and pit out, order dated January 27, 2025 -nystatin powder 100,000 units; apply to reddened area of groin folds twice a day, order dated January 27, 2025 -Zinc Oxide 6% cream; apply one application to left groin and buttocks twice a day for skin irritation, order dated September 22, 2025 -miconazole 2% powder; apply topically to groin area twice daily, order dated March 25, 2025 On December 9, 2025, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's medications to administer. ULP-E compared each medication to the order listed in the medication administration record (MAR). ULP-E	01760			

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01760	Continued From page 28 read and immediately documented that she administered R3's ammonium Lac 12% cream, diclofenac gel, nystatin powder, SF 5000 plus cream, miconazole powder and zinc oxide. ULP-E stated the ULP assigned to R3's personal cares administered all powders, gels and creams while they did morning cares; however, ULP-E documented the administration. The surveyor inquired how she knew the ordered creams, powders and gels were administered and she stated the caregivers just knew to put them on as part of morning cares. On December 10, 2025, at 10:32 a.m., interim clinical nurse supervisor (ICNS)-B stated currently all creams, powders and gels were listed in R3's MAR for the ULP passing medications to administer. However, the caregivers (not passing medications) are typically the ones to administer topical medications and didn't have access to the MAR to document when they administered the topical medications. ICNS-B stated the licensee was in the process of removing the topical medications listed on the MAR and instead list them under the services that the caregivers complete, so it reflects which staff administered the topical medication. The licensee's Unlicensed Personnel-Medication Administration policy dated August 1, 2021, indicated ULP that provide assistance with medication administration will document medication administration, consistent with the agency's procedures for documenting the MAR. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01880	Continued From page 29	01880			
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. This had the potential to affect 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 December 8, 2025, at 12:08 p.m., the surveyor observed an unattended medication cart unlocked near the memory care dining room. The surveyor observed unlicensed personnel (ULP)-D go to the medication cart, remove keys from her pocket to unlock the medication cart, but noticed that the medication cart was already unlocked. ULP-D stated, "if I'm being honest, my biggest problem is forgetting to lock the cart". ULP-D stated the medication cart should be locked when unattended.	01880			

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01880	Continued From page 30 On December 9, 2025, at 7:55 a.m., the surveyor observed an unattended and unlocked medication cart in the memory care common area. The surveyor observed ULP-E prepare medications for R1, brought R1's medications to his room to administer, leaving the medication cart unlocked. ULP-E returned to the medication cart after administering R1's medications, documented the medication administration, walked away from the unlocked medication cart to remind R2 it was time for breakfast. ULP-E returned to the medication cart and waited for R2 to come out of his room. When R2 came out of his room, ULP-E escorted him to the dining room, leaving the medication cart unlocked and unattended. On December 10, 2025, at 10:05 a.m., interim clinical nurse supervisor (ICNS)-B stated the medication cart should be locked when not in use and when staff are not present at the cart. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated when secured storage of the medications is necessary, the nurse will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890			

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01890	Continued From page 31 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders dated January 27.2025, included the following: -albuterol 90 micrograms (mcg) inhaler; inhale two puffs into the lungs twice daily R3's medication administration record included the following:	01890			

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01890	Continued From page 32 -albuterol inhaler; inhale two puffs into the lungs twice daily. If opening a new inhaler, label box with date opened and date medication expires (expires 12 months after opening or by expiration date on box; whichever comes first) On December 9, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's medications and albuterol inhaler. The inhaler had a sticker on it for staff to document the open date; however, it was blank. ULP-E verified the inhaler did not have an open date on it. ULP-E stated they were expected to document the open date on inhalers after the first use. On December 10, 2025, at 10:35 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the ULP to document the open date for all inhalers at the time a new one is first used. Albuterol (Ventolin) inhaler instructions for use dated December 20, 2014, indicated the inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective pouch, whichever comes first. The licensee's Medication management Services policy dated August 1, 2021, Indicated the nurse would review each client's (resident's) medication record, during the client (resident) monitoring visit, to verify that staff are administering the medications as prescribed and are documenting the administration appropriately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01900	Continued From page 33		01900		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a prescription for continuous glucose monitor for one resident was not being used for another resident with blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 9, 2025, at 6:47 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to check R1's blood glucose. ULP-E looked for R1's glucometer (device used to check blood sugar) in his room and in the medication cart. ULP-E could not locate R1's glucometer and stated she would go check the other medication cart because R1 and R4 had the same glucometer and could borrow R4's. ULP-E went to the second medication cart and returned with R4's glucometer. ULP-E entered R1's room and attempted to scan R1's sensor with R4's glucometer but it would not register. ULP-E stated since she was unable to check R1's blood sugar		01900		

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01900	Continued From page 34 via his sensor, she would have to check R1's blood sugar via a finger poke. ULP-E returned to the medication cart and removed a glucometer that the surveyor observed ULP-D check R2's blood sugar on December 8, 2025. ULP-E brought the glucometer into R1's room and checked his blood sugar via finger poke and returned to the glucometer to the medication cart without disinfecting it. The surveyor inquired if ULP-E had just used a shared glucometer or R2's personal glucometer for R1. ULP-E stated R1 did not have his own glucometer and borrowed R2's supplies. On December 10, 2025, at 10:12 a.m., interim clinical nurse supervisor (ICNS)-B stated the ULP were not supposed to use or borrow another resident's supplies. ICNS-B stated the glucometer used for R2 was provided by the facility when his sensor no longer worked. ICNS-B stated technically the ULP could use the facility glucometer for multiple residents as long as the glucometer was disinfected between use. However, ICNS-B stated the licensee had several glucometers for the ULP to use so that residents did not have to share glucometers (even facility provided ones). ICNS-B stated she would educate the staff on not using other resident supplies and the availability of additional glucometers that can be used when needed. The licensee's Disinfecting of Reusable Equipment and Surfaces policy dated August 1, 2021, indicated reusable equipment and environmental surfaces will be properly disinfected. Whenever possible, clients (residents) will have their own reusable equipment and the equipment will not be shared with other clients or residents.	01900			

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01900	Continued From page 35 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01910			

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01910	Continued From page 36 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: R6 was admitted to the licensee on October 30, 2024, and discharged on October 19, 2025. R6's Medication Disposition/Disposal Record form dated October 25, 2025, had seven columns that identified the date, medication name and dosage, prescription number, quantity, method of disposition, registered nurse (RN) signature and title, and witness signature and title. Several medications listed on the disposition form did not include the dose of the medication. On December 10, 2025, at 10:42 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R6's medication disposition form and stated not all medications listed include the dose as required. The licensee's Disposition of Medication/Legend and Controlled substances policy dated August 1, 2021, indicated documentation of the medication destruction must be kept in the client's (resident's) record. The documentation includes, but not limited to; name of the client (resident), date, quantity, name of drug, prescription number, and signature of person destroying the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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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: SL29049016-0 On December 8, 2025, through December 10, 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 101 residents; 78 receiving services under the Assisted Living Facility with Dementia Care 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.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
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0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100			

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0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to obtain accurate licensure when they applied for licensure for an assisted living facility, despite sharing one roof with an adjoining church in the same building, without having an approved two-hour fire wall. 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: The licensee's health facility identification (HFID) 29049 was located at 9850 163rd Street West, Lakeville, Minnesota (MN) 55044, and was attached to 9600 163rd Street West, Lakeville, MN 55044, by a shared interior vestibule wall and not part of the licensed assisted living facility.	0 100			

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0 100	Continued From page 3 On December 11, 2025, at approximately 10:15 a.m., Minnesota Department of Health (MDH) environmental engineer (EE) survey staff toured the facility with environmental services director (ESD)-G. During the tour, EE survey staff observed the vestibule which did not show indication of fire rated construction separating the buildings on either side. The doors, frames, glass and assemblies of the vestibule did not contain indication of fire-rating ESD-G stated everything past the vestibule was not part of the licensed space for the assisted living facility. ESD-G further stated the licensee did not possess the ability to access spaces beyond the vestibule. ESD-G stated they were unaware of any further fire barrier separating the licensed assisted living facility from the church facility. ESD-G indicated they could not locate evidence of separation between facilities/occupancies. No further documentation was provided. No evidence of fire barrier separation was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480			

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0 480	Continued From page 4 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480			

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0 480	Continued From page 5 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 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	0 510			

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0 510	Continued From page 6 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of two employees (unlicensed personnel (ULP)-C and ULP-E). 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 December 8, 2025, at 11:16 a.m., the surveyor observed ULP-C prepare to check R2's blood sugar. ULP-C stated R2 had a Libre Sensor (device that continuously monitors blood sugar); however, it had been giving inaccurate readings, so the ULP were manually checking R2's blood	0 510			

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0 510	Continued From page 7 sugar via finger poke using the facility's glucometer. ULP-C gathered the facility glucometer, alcohol prep pad and lancet and went to R2's room and checked R2's blood sugar. ULP-C returned to the medication cart and placed the glucometer back in the medication cart drawer without disinfecting it. On December 9, 2025, at 6:54 a.m., the surveyor observed ULP-E check R1's blood sugar with the facility's glucometer. After checking R1's blood sugar, ULP-E returned to the medication cart, disposed of the test strip in the sharps container, remove gloves, documented R1's blood sugar results and place the facility glucometer back in the medication cart. ULP-E did not perform hand hygiene after she removed gloves and did not disinfect the glucometer after using it. On December 9, 2025, at 7:06 a.m., the surveyor observed ULP-E log into the electronic health record via laptop, put gloves on, remove medication cards from the drawer, compare each medication to the order in the medication administration record (MAR), punch each medication into a medication cup and gather R3's inhaler and nasal spray. ULP-E brought the medications to R3 who was sitting at the puzzle table. While administering R3's medications, ULP-E wiped her nose twice with her gloved hand. ULP-E then returned to the medication cart, removed the spacer from R3's inhaler and brought the spacer into R2's room (different resident) to clean and wash it. After cleaning R3's spacer she returned to the medication cart, put the spacer away and then removed gloves. ULP-E documented R3's medication administration. ULP-E wore the same pair of gloves during the entire observation noted above and did not perform hand hygiene after removing	0 510			

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0 510	Continued From page 8 gloves. On December 9, 2025, at 7:55 a.m., the surveyor observed ULP-E put gloves on, removed R1's medication cards from the medication cart, compare each medication to the order in the MAR, punch each medication into a medication cup. ULP-E wiped her nose with her gloves hand and then dumped the medications that were in the medication cup onto a Kleenex. ULP-E then used her gloved hand to count each medication and put them back into the medication cup. ULP-E then gathered R1's medications, insulin and laptop and brought them to R1's room. ULP-E prepared and administered R1's insulin then logged into the laptop to verify which site to place R1's patch on. ULP-E applied R1's patch to his left upper back and then removed the old patch and disposed of it. ULP-E then left R1's room to get a Kleenex, returned and administered R1's eye drops, assisted R1 to a sitting position, administered his oral medications and nasal spray. ULP-E returned to the medication cart, removed gloves, did not perform hand hygiene and documented medication administration on the laptop. ULP-E wore the same pair of gloves for the entire observation noted above. On December 10, 2025, at 10:06 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the staff to perform hand hygiene prior to applying gloves and again after gloves were removed. ICNS-B further stated staff should change gloves between performing different tasks. The licensee's Gloves-Procedure for Using policy dated August 1, 2021, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body	0 510			

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0 510	Continued From page 9 fluids, non-intact skin, secretions, feces, or a contaminated item or surface, such as soiled linens or wound dressing. Gloves will be removed carefully and disposed of in a proper container. The licensee's Disinfecting of Reusable Equipment and Surfaces policy dated August 1, 2021, indicated reusable equipment and environmental surfaces will be properly disinfected. Whenever possible, clients (residents) will have their own reusable equipment, and the equipment will not be shared with other clients or residents. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four residents' (R1) personal health and medical information was kept private. This practice resulted in a level two violation (a	0 700			

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0 700	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 9, 2025, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to administer medications to R1. ULP-E logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. ULP-E left R1's record open on the laptop screen which was visible to others. ULP-E returned to the medication cart, documented the administration of R1's medication and went to R2's room to remind him to go to breakfast. ULP-E left R1's record open on the laptop screen, which was visible to others. On December 9, 2025, at 8:30 a.m., ULP-E stated they were supposed to log off or close the laptop screen when not using it to protect resident information. On December 10, 2025, at 10:42 a.m., interim clinical nurse supervisor (ICNS)-B stated all staff were trained to keep resident records confidential and private from any unauthorized individuals. The licensee's Client Record Confidentiality policy dated August 1, 2021, indicated client (resident) records and client information will be kept confidential. Access to paper and electronic client records will be limited to only the information needed by employees, contractors, other health	0 700			

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0 700	Continued From page 11 care providers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a client ' s health or safety but had the potential to have harmed a client ' 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 clients). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Deccember 11, 2025, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775			

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0 775	Continued From page 12	0 775			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency training and evaluations were completed by one of one volunteer (V)-F prior to providing direct cares. 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	01330			

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01330	Continued From page 13 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 8, 2025, at 11:56 a.m., the surveyor observed V-F in the dining room feeding R5 her modified diet. -at 12:05 p.m., unlicensed personnel (ULP)-C stated V-F's grandmother resided at the facility and when V-F visited, she would also volunteer. ULP-C stated V-F frequently assisted residents in the dining room during mealtimes, including feeding R5. -at 12:20 p.m., V-F stated her grandmother resided at the facility. V-F stated she helped the staff with residents whenever she could during her visits with her grandmother. On December 9, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A stated V-F did not have scheduled volunteered hours unless it was for a planned event. The surveyor inquired if V-F had a employee record that included training. LALD-A provided the surveyor V-F's employee record which contained a volunteer application dated May 17, 2024, volunteer emergency medication information form, a background study clearance letter, and volunteer agreement dated May 17, 2024. On December 9, 2025, at 9:29 a.m., interim clinical nurse supervisor (ICNS)-B and regional nurse (RN)-H stated V-F was not trained or competency tested on delegated tasks which included modified diets or feeding assistance. RN-H stated V-F should not assist residents (outside of her own family member) with feeding	01330			

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NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT HOSANNA			STREET ADDRESS, CITY, STATE, ZIP CODE 9850 163RD STREET WEST LAKEVILLE, MN 55044		
(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
01330	Continued From page 14 as she had not been trained. RN-H stated the licensee had already sent a notification out to all volunteers clarifying that as volunteers they could not complete delegated tasks. ICNS-B stated the staff were also educated on this topic and to notify nursing if they have questions on what volunteers are able to do with residents. The licensee's Volunteer Onboarding policy dated August 2023, indicated persons who volunteer will go through an onboarding process. The procedure includes the following: 1. Potential volunteer submits an application 2. Volunteer/Active Living Coordinator schedules an interview with applicant 3. The Volunteer/Active Living Coordinator has the applicant sign off on the following onboarding forms, including but not limited to: Ebenezer Volunteer Agreement (if Handbook is not provided) and Ebenezer Volunteer Nondisclosure Agreement (if Handbook is not provided) 4. Volunteers are to be treated as ancillary employees for orientation, attending NEO (new employee orientation) Day 1 and Day 2 and completing dementia training. 5. Volunteers are oriented to the community and to the department/area in which they are volunteering. 6. All volunteers have a paper or electronic personnel file that is maintained by Volunteer Services. 7. Volunteers who volunteer ten (10) hours or more per week are required to complete the TB Screening Tool for Health care workers process. 8. Background checks and TB screening forms are kept in a secure location in the Volunteer/Active Living Coordinator's Office at each site. The licensee's Orientation and Training:	01330			

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01330	Continued From page 15 Employee policy dated January 1, 2025, indicated all staff providing and supervising direct services will complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days		01330		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents for one of one volunteer (V-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:		01480		

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01480	Continued From page 16 R5 was admitted on September 1, 2016, with diagnoses that included dementia. R5's service plan dated December 2, 2025, indicated R2 received assistance to include Dining: Feeding Assist and texture modified diet (resident is on mechanical soft diet with thin liquids). R5's Service Checkoff List dated December 2025, included the following: -Dietary: Texture Modified: Resident is on mechanical soft diet with thin liquids. Prepare food item per specialty diet requirements -Dining: Feeding Assist: Resident pockets foods. Encourage alternating solids and liquids. If pocketing, stop feeding and re-attempt later. No place mat- it is too distracting for her and then she won't eat. Unlicensed staff to physically assist resident to eat and drink meals supporting independence where possible. Staff to report any difficulty with swallowing, coughing or choking during meals. On December 8, 2025, at 11:56 a.m., the surveyor observed V-F in the dining room feeding R5 her modified diet. V-F's employee record lacked evidence of orientation to each specific resident and services provided. On December 9, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A provided the surveyor V-F's employee record which did not contain any orientation or training documents. On December 9, 2025, at 9:29 a.m., interim clinical nurse supervisor (ICNS)-B and regional	01480			

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01480	Continued From page 17 nurse (RN)-H stated V-F had not been trained or competency tested on any resident services or orientation to each specific resident and services provided. RN-H stated V-F was not trained because she should not have been providing services to any resident besides her own grandmother who resided at the facility. The licensee's Orientation and Training: Employee policy dated January 1, 2025, indicated all staff providing and supervising direct services will complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation to Assisted living would include: -oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01480			
01620 SS=E	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	01620			

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01620	Continued From page 18 is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in 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.	01620			

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01620	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for four of four residents (R1, R2, R3 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 was admitted on March 12, 2023, with diagnoses that included diabetes R1's service plan dated December 2, 2025, indicated R1 received assistance with services to include grooming, dressing, bathing, safety checks, behavior management plan, modified diet, blood pressure monitoring, diabetic management and medication administration. R1's ongoing nursing assessments dated May 16, 2025, August 18, 2025, and November 19, 2025, were reviewed. The August 18, 2025, assessment was completed 94 days after the date of the previous assessment, thus exceeding 90 calendar days. R2	01620			

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01620	Continued From page 20 R2 was admitted on June 27, 2025, with diagnoses that included diabetes. R2's service plan dated July 11, 2025, indicated R2 received assistance with services to include grooming, dressing, bathing, transfers, bed mobility, ambulation, safety checks, behavior management plan, vital sign monitoring, diabetic management and medication administration. R2's ongoing nursing assessments dated June 27, 2025, July 7, 2025, July 11, 2025, and October 11, 2025, were reviewed. The October 11, 2025, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. R3 R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include grooming, dressing, bathing, toileting, bed mobility, transfer assist, modified diet, Velcro compression, Rooke boot, oxygen, and medication administration. R3's ongoing nursing assessments dated March 26, 2025, June 26, 2025, and September 25, 2025, were reviewed. The June 26, 2025, assessment was completed 92 days after the date of the previous assessment and the September 25, 2025, assessment was completed 91 days after the date of the previous assessment, thus both exceeded 90 calendar days. R4 R4 was admitted on November 3, 2021, with	01620			

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01620	Continued From page 21 diagnoses that included diabetes. R4's service plan dated April 6, 2025, indicated R4 received assistance with services to include bathing, diabetic management and medication administration. R4's ongoing nursing assessments dated June 4, 2025, September 2, 2025, and December 2, 2205, were reviewed. The December 2, 2025, assessment was completed 91 days after the previous assessment, thus exceeding 90 calendar days. On December 10, 2025, at 10:21 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the nurses to complete all assessments within the required time frame. ICNS-B stated she would review how to pull a report within their electronic health record system that provides due dates for all resident assessments with the nurses. The licensee's Assessments of Clients- Initial and Ongoing policy dated May 23, 2022, indicated resident reassessment and monitoring will be conducted no more than 14 calendar days after initiation of services. Ongoing client (resident) reassessment and monitoring will be conducted as needed, based on changes in the needs of the client (resident) and not to exceed 90 calendar days from the client's (resident's) last date of the uniform assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

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01730	Continued From page 22	01730			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that 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 23 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 plan with the required content for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at approximately 9:45 a.m., interim clinical nurse supervisor (ICNS)-B stated resident medications were stored mainly in a medication cart; however, overflow medications were stored in the nurse's office and medications requiring refrigeration were stored in a secured refrigerator. R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025,	01730			

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01730	Continued From page 24 indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders included the following: -ammonium Lac-12% cream; apply one application topically to lower legs and feet twice daily, order dated January 27, 2025 -diclofenac sodium 1% gel; apply 4 grams topically to knees twice daily, order dated January 27, 2025 -SF 5000 Plus cream 1.1 %; small amount to brush teeth for two minutes twice a day and spit out, order dated January 27, 2025 -Nystatin powder 100,000 units; apply to reddened area of groin folds twice a day, order dated January 27, 2025 -Zinc Oxide 6% cream; apply one application to left groin and buttocks twice a day for skin irritation, order dated September 22, 2025 -miconazole 2% powder; apply topically to groin area twice daily, order dated March 25, 2025 On December 9, 2025, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R3. ULP-E stated the caregivers administered R3's topical medications which were stored in a locked cabinet in R3's room. R3's medication management plan dated September 25, 2025, included within the comprehensive assessment indicated the following: -Medications are kept in a locked medication cart -Resident has controlled medications. Medications are secured with a double lock system R3's medication management plan did not	01730			

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01730	Continued From page 25 include the locked cabinet in R3's room that stored his topical medications. On December 10, 2025, at 10:38 a.m., ICNS-B stated the licensee was in the process of updating medication management plans to reflect topical medications being stored in the resident's room for the caregivers to administer. The licensee's Medication Management Services policy dated August 1, 2021, indicated the RN will develop an individualized medication management plan for each client (resident) receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	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.	01750			

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01750	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-E) completed medication administration according to manufacturer instructions observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on March 12, 2023, with diagnoses that included diabetes R1's service plan dated December 2, 2025, indicated R1 received assistance with diabetic management and medication administration. R1's medication administration record (MAR) dated December 2025, included the following: -Lantus insulin, inject 18 units subcutaneously once daily On December 9, 2025, at 7:55 a.m., the surveyor observed ULP-E prepare R1's Lantus insulin. ULP-E cleansed the back of R1's left arm with an alcohol prep pad, injected the insulin, then immediately removed the pen/needle from R1's	01750			

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NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT HOSANNA			STREET ADDRESS, CITY, STATE, ZIP CODE 9850 163RD STREET WEST LAKEVILLE, MN 55044		
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01750	Continued From page 27 arm once administered. R3 R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's medication administration record (MAR) dated December 2025, included the following: -albuterol 90 micrograms (mcg); inhale two puffs into the lungs twice daily -fluticasone spray 50 mcg; spray one spray in each nostril once daily On December 9, 2025, at 7:06 a.m., the surveyor observed ULP-E prepare R3's medications which included an albuterol inhaler and fluticasone nasal spray. ULP-E brought R3's medications, inhaler and nasal spray to R3 who was sitting at the puzzle table. ULP-E instructed R3 to open his mouth and ULP-E administered two puffs of the albuterol inhaler without waiting in between puffs. R3 did not inhale while the puffs were administered as ULP-E did not provide any instructions to him besides to open his mouth. ULP-E then administered one spray of fluticasone nasal spray into each nostril. R3 did not inhale with each spray as ULP-E did not provide any instruction to him. On December 10, 2025, at 10:19 a.m., interim clinical nurse supervisor (ICNS)-B stated expectation with insulin pen administration would be to hold the insulin pen against the skin for five to 10 seconds prior to removing the needle from the skin. ICNS-B stated she expected the ULP to provide instructions to the residents when they	01750			

Minnesota Department of Health

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01750	Continued From page 28 are administering inhalant medications and to wait one to two minutes between puffs. The Lantus SoloStar pen manufacturer's instructions dated 2022, indicated: Step 5. Inject your dose - Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) - Release the button and remove the needle from your skin. The albuterol inhaler manufacturer's instructions dated 1. Shake the inhaler well before each spray. Take the cap off the mouthpiece of the actuator. Look inside the mouthpiece for foreign objects and take out any you see. 2. Hold the inhaler with the mouthpiece down 3. Breath out through your mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close your lips around it 4. Push the top of the canister all the way down while you breathe in deeply and slowly through your mouth 5. After the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth 6. Hold your breath for about 10 seconds, or for as long as is comfortable. Breathe out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait one minute and shake the inhaler again. Repeat steps two through six. No further information was provided.	01750			

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01750	Continued From page 29	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01760			

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01760	Continued From page 30 R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders included the following: -ammonium Lac-12% cream; apply one application topically to lower legs and feet twice daily, order dated January 27, 2025 -diclofenac sodium 1% gel; apply 4 grams topically to knees twice daily, order dated January 27, 2025 -SF 5000 Plus cream 1.1 %; small amount to brush teeth for two minutes twice a day and spit out, order dated January 27, 2025 -nystatin powder 100,000 units; apply to reddened area of groin folds twice a day, order dated January 27, 2025 -Zinc Oxide 6% cream; apply one application to left groin and buttocks twice a day for skin irritation, order dated September 22, 2025 -miconazole 2% powder; apply topically to groin area twice daily, order dated March 25, 2025 On December 9, 2025, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's medications to administer. ULP-E compared each medication to the order listed in the medication administration record (MAR). ULP-E read and immediately documented that she administered R3's ammonium Lac 12% cream, diclofenac gel, nystatin powder, SF 5000 plus cream, miconazole powder and zinc oxide. ULP-E stated the ULP assigned to R3's personal cares administered all powders, gels and creams while they did morning cares; however, ULP-E	01760			

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01760	Continued From page 31 documented the administration. The surveyor inquired how she knew the ordered creams, powders and gels were administered and she stated the caregivers just knew to put them on as part of morning cares. On December 10, 2025, at 10:32 a.m., interim clinical nurse supervisor (ICNS)-B stated currently all creams, powders and gels were listed in R3's MAR for the ULP passing medications to administer. However, the caregivers (not passing medications) are typically the ones to administer topical medications and didn't have access to the MAR to document when they administered the topical medications. ICNS-B stated the licensee was in the process of removing the topical medications listed on the MAR and instead list them under the services that the caregivers complete, so it reflects which staff administered the topical medication. The licensee's Unlicensed Personnel-Medication Administration policy dated August 1, 2021, indicated ULP that provide assistance with medication administration will document medication administration, consistent with the agency's procedures for documenting the MAR. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880			

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01880	Continued From page 32 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. This had the potential to affect 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 December 8, 2025, at 12:08 p.m., the surveyor observed an unattended medication cart unlocked near the memory care dining room. The surveyor observed unlicensed personnel (ULP)-D go to the medication cart, remove keys from her pocket to unlock the medication cart, but noticed that the medication cart was already unlocked. ULP-D stated, "if I'm being honest, my biggest problem is forgetting to lock the cart". ULP-D stated the medication cart should be locked when unattended. On December 9, 2025, at 7:55 a.m., the surveyor observed an unattended and unlocked medication cart in the memory care common area. The surveyor observed ULP-E prepare medications for R1, brought R1's medications to his room to administer, leaving the medication	01880			

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01880	Continued From page 33 cart unlocked. ULP-E returned to the medication cart after administering R1's medications, documented the medication administration, walked away from the unlocked medication cart to remind R2 it was time for breakfast. ULP-E returned to the medication cart and waited for R2 to come out of his room. When R2 came out of his room, ULP-E escorted him to the dining room, leaving the medication cart unlocked and unattended. On December 10, 2025, at 10:05 a.m., interim clinical nurse supervisor (ICNS)-B stated the medication cart should be locked when not in use and when staff are not present at the cart. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated when secured storage of the medications is necessary, the nurse will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890			

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01890	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on March 7, 2020, with diagnoses that included dementia. R3's service plan dated January 1, 2025, indicated R3 received assistance with services to include medication administration. R3's signed prescriber orders dated January 27.2025, included the following: -albuterol 90 micrograms (mcg) inhaler; inhale two puffs into the lungs twice daily R3's medication administration record included the following: -albuterol inhaler; inhale two puffs into the lungs twice daily. If opening a new inhaler, label box with date opened and date medication expires (expires 12 months after opening or by expiration date on box; whichever comes first) On December 9, 2025, at 7:11 a.m., the surveyor	01890			

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01890	Continued From page 35 observed unlicensed personnel (ULP)-E prepare R3's medications and albuterol inhaler. The inhaler had a sticker on it for staff to document the open date; however, it was blank. ULP-E verified the inhaler did not have an open date on it. ULP-E stated they were expected to document the open date on inhalers after the first use. On December 10, 2025, at 10:35 a.m., interim clinical nurse supervisor (ICNS)-B stated she expected the ULP to document the open date for all inhalers at the time a new one is first used. Albuterol (Ventolin) inhaler instructions for use dated December 20, 2014, indicated the inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective pouch, whichever comes first. The licensee's Medication management Services policy dated August 1, 2021, Indicated the nurse would review each client's (resident's) medication record, during the client (resident) monitoring visit, to verify that staff are administering the medications as prescribed and are documenting the administration appropriately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced	01900			

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01900	Continued From page 36 by: Based on observation, interview, and record review, the licensee failed to ensure a prescription for continuous glucose monitor for one resident was not being used for another resident with blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 9, 2025, at 6:47 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to check R1's blood glucose. ULP-E looked for R1's glucometer (device used to check blood sugar) in his room and in the medication cart. ULP-E could not locate R1's glucometer and stated she would go check the other medication cart because R1 and R4 had the same glucometer and could borrow R4's. ULP-E went to the second medication cart and returned with R4's glucometer. ULP-E entered R1's room and attempted to scan R1's sensor with R4's glucometer but it would not register. ULP-E stated since she was unable to check R1's blood sugar via his sensor, she would have to check R1's blood sugar via a finger poke. ULP-E returned to the medication cart and removed a glucometer that the surveyor observed ULP-D check R2's blood sugar on December 8, 2025. ULP-E brought the glucometer into R1's room and checked his blood sugar via finger poke and	01900			

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01900	Continued From page 37 returned to the glucometer to the medication cart without disinfecting it. The surveyor inquired if ULP-E had just used a shared glucometer or R2's personal glucometer for R1. ULP-E stated R1 did not have his own glucometer and borrowed R2's supplies. On December 10, 2025, at 10:12 a.m., interim clinical nurse supervisor (ICNS)-B stated the ULP were not supposed to use or borrow another resident's supplies. ICNS-B stated the glucometer used for R2 was provided by the facility when his sensor no longer worked. ICNS-B stated technically the ULP could use the facility glucometer for multiple residents as long as the glucometer was disinfected between use. However, ICNS-B stated the licensee had several glucometers for the ULP to use so that residents did not have to share glucometers (even facility provided ones). ICNS-B stated she would educate the staff on not using other resident supplies and the availability of additional glucometers that can be used when needed. The licensee's Disinfecting of Reusable Equipment and Surfaces policy dated August 1, 2021, indicated reusable equipment and environmental surfaces will be properly disinfected. Whenever possible, clients (residents) will have their own reusable equipment and the equipment will not be shared with other clients or residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900			

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01910	Continued From page 38	01910			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01910			

Minnesota Department of Health

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01910	Continued From page 39 The findings include: R6 was admitted to the licensee on October 30, 2024, and discharged on October 19, 2025. R6's Medication Disposition/Disposal Record form dated October 25, 2025, had seven columns that identified the date, medication name and dosage, prescription number, quantity, method of disposition, registered nurse (RN) signature and title, and witness signature and title. Several medications listed on the disposition form did not include the dose of the medication. On December 10, 2025, at 10:42 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R6's medication disposition form and stated not all medications listed include the dose as required. The licensee's Disposition of Medication/Legend and Controlled substances policy dated August 1, 2021, indicated documentation of the medication destruction must be kept in the client's (resident's) record. The documentation includes, but not limited to; name of the client (resident), date, quantity, name of drug, prescription number, and signature of person destroying the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

THE FOUNTAINS AT HOSANNA
9850 163rd Street West
Lakeville, MN 55044
Dakota County
Parcel:

Phone:

License Info

License: HFID 29049

Risk:
License:
Expires on:
CFPM: Christopher Nowak
CFPM #: 13628; Exp: 03/26/2027

Inspection Info

Report Number: F8044251288
Inspection Type: Full - Single
Date: 12/9/2025 Time: 8:56:20 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.15A *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0287A Single-use gloves must be used for only one task and be discarded when damaged or soiled, or when interruptions occur in the operation.

COMMENT: Observed staff use gloves contaminated from touching earbud and soiled rag to handle clean equipment without first changing gloves.

Comply By: 12/9/2025 Originally Issued On: 12/9/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Chris Nowak and Brandi Fitch.

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 Rochester District Office inspection report number F8044251288 from 12/9/2025

Chris Nowak
Culinary Director


Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

THE FOUNTAINS AT HOSANNA
Lakeville
County/Group: Dakota County

Inspection Info

Report Number: F8044251288
Inspection Type: Full
Date: 12/9/2025
Time: 8:56:20 AM

Food Temperature: Product/Item/Unit: Eggs; **Temperature Process:** Hot-Holding

Location: Steam Table at 181.4 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Turkey; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 36.9 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Walk-in Cooler at 32.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Boiled eggs; **Temperature Process:** Cold-Holding

Location: Upright Cooler 1 at 37.0 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler 1 at 36.0 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler 3 at 35.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Baked potatoes; **Temperature Process:** Cold-Holding

Location: Upright Cooler 3 at 33.9 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler 3 at 34.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Chicken; **Temperature Process:** Cold-Holding

Location: Prep Cooler at 34.8 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Prep Cooler at 33.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Taco meat; **Temperature Process:** Re-Heating

Location: Oven at 190.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: Memory Care Upright Cooler at 36.5 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Memory Care Upright Cooler at Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

THE FOUNTAINS AT HOSANNA
Lakeville
County/Group: Dakota County

Inspection Info

Report Number: F8044251288
Inspection Type: Full
Date: 12/9/2025
Time: 8:56:20 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 170.0 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Prep Area **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** 3-Compartment Sink

Location: Dishwashing Area **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Memory Care **Equal To** 170.0 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: Memory Care **Equal To** 400 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL29049016	Date: 12/11/2025
Facility Name: Fountains at Hosana	
Facility Address: 9850 163 rd Street West, Lakeville, MN 55044	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; WidespreadTIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: The pathway outside of the egress door leading to the exterior from stairwell 1 was not shoveled and had a significant amount of snow that obstructed egress. The egress path should be cleared of snow and maintained free of obstruction.

3. A working space of not less than 30 inches (762 mm) in width, 36 inches (914 mm) in depth and 78 inches (1981 mm) in height shall be provided in front of electrical service equipment. Where the electrical service equipment is wider than 30 inches (762 mm), the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: Two large shelves with miscellaneous items were stored in front of the electrical panel in mechanical closet 179 which obstructed access to the panel. Proper clearance should be maintained around the panel.

4. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: Unapproved multiplug adapters were in use in resident room 311 and resident room 314.

5. Fueled equipment including, but not limited to, motorcycles, mopeds, lawn-care equipment, portable generators and portable cooking equipment, shall not be stored, operated or repaired within a building. [Minn. Stat. 144G.45 subd. 2; MSFC 313.1]

Comments: Containers of gasoline and a fueled pressure washer were stored in the riser room, sitting on the floor.

6. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: No signal or switch was present in any approved location that would unlock the controlled locking system of the memory care unit. Blue pull boxes were located at the controlled egress doors and environmental services director stated they would unlock individual doors but not break power to locking system and release all doors.

7. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Extension cords were in use in lieu of permanent wiring in resident room 314 to power the television, activities director office to power multiple electronics, and in the vestibule to power holiday lights. The environmental services director confirmed that the noted extension cords were used as permanent wiring.

8. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

Comments: Two sprinkler heads in the spa room had tape from maintenance work around them and were missing escutcheons.