DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

November 06, 2025

Licensee
Push Services Inc.
4756 Maryland Avenue North
Crystal, MN 55428

RE: Denial of License Number 419726
Health Facility Identification Number (HFID) 41007
Initial survey; Project Number(s) SL41007015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 18, 2025 for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

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

REQUEST FOR RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jess Schoenecker, via email at: jess.schoenecker@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **11/09/2025**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Jess Schoenecker, Supervisor, at jess.schoenecker@state.mn.us. Jess Schoenecker can also be reached by office phone at 651-201-3789.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

(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: SL41007015-0 On September 16, 2025, through September 18, 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 two (2) residents; 2 receiving services under the Provisional Assisted Living Facility license. On September 16, 2025, an immediate correction order was issued for tag identification 0470. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure owner/licensed assisted living director (O/LALD) held a Shared Director certificate issued by the Board of Executives for Long Term Services and Supports (BELTSS). Additionally, O/LALD-A failed to ensure they were listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 16, 2025, at 10:15 a.m., O/ LALD-A stated they were listed as director of record for licensee. The surveyor observed a copy of O/LALD-A's license posted in the common area.	0 110		

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0 110	Continued From page 2 On September 16, 2025, at 10:15 a.m., the surveyor informed O/LALD-A that they were not listed as director of record for licensee. O/LALD-A stated they had notified BELTSS of their director of record status. O/LALD-A stated they did not have a shared director certificate for health facility identification (HFID) 41007. On September 22, 2005, at 3:52 p.m., the BELTSS website indicated O/LALD-A currently held an assisted living director license effective through October 31, 2025. The website indicated O/LALD-A was the Director of Record for another HFID (37222). The licensee's 4.01 Assisted Living Director policy dated August 1, 2021, indicated [licensee] was required to have an assisted living director licensed or permitted by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by:	0 420		

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0 420	Continued From page 3 Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a provisional assisted living facility license, effective February 11, 2025, with an expiration date of February 10, 2026. The licensee's Provisional Assisted Living Licensure Information and Application, section titled Official Verification of Owner or Authorized Agent, (page 16 and 17 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: -Assisted Living Licensure statutes in Minnesota Statute chapter 144G -Assisting Living Licensure rules in Minnesota Rules, chapter 4659 -Reporting of Maltreatment of Vulnerable Adults -Electronic Monitoring in Certain Facilities -I understand pursuant to Minnesota Statute section 13.04 Rights of Subjects of Data (opens in a new window), the commissioner will use information provided in this application, which	0 420		

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0 420	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal, or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective proves. Types of offices include Adult Protective Services, office of the ombudsmen, health licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of	0 420		

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0 420	Continued From page 5 Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 17 was signed by owner/licensed assisted living director (O/LALD)-A on January 9, 2023 As a result of this survey, the following orders were issued 0110, 0470, 0480, 0550, 0630, , 0660, 0680, 0775, 0800, 0810, 1290, 1370, 1380, 1440, 1470, 1530, 1640, 1650, 1760, 1880, 1940, 1960, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required	0 470		

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0 470	Continued From page 6 by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing 24 hours per day, seven days per week, to meet the scheduled and reasonably foreseeable unscheduled needs of each resident and to ensure the facility could respond promptly and effectively in the event of an emergency. 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	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 470	Continued From page 7 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan signed on March 21, 2025, indicated R1's services included assistance with dressing, grooming, bathing, behavior management, medication administration, bed mobility, and repositioning. R1's nursing assessment (page 1) dated May 2, 2025, indicated mobility and transfer needs included an assistive device to transfer. R1's record read "Sit-to-stand lift Patient was discharge [sic] with an E-Z lift [a sit-to-stand mechanical lift] for all transfers. however, patient has been using Hoyer lift [full body mechanical lift] for all transfers. Patient is currently being evaluated by PT to determined appropriate transfer status". R1's record included a physician progress note dated April 25, 2025, indicating R1 used a Hoyer lift for transfers. On September 16, 2025, at 10:35 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A stated that one caregiver was staffed each of three shifts (8:00 a.m., through 4:00 p.m., 4:00 p.m. through 10:00 p.m., and 10:00 p.m., through 8:00 a.m.). O/LALD-A stated R1 used a Hoyer lift with the assistance of two staff members for all transfers. O/LALD-A stated that if assistance was needed with using the Hoyer lift, a staff person from the assisted living facility next door (under the same ownership) would come over to assist.	0 470		

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0 470	Continued From page 8 On September 16, 2024, at 12:14 p.m., the surveyor observed O/LALD-A and unlicensed personnel (ULP)-C transferring R1 using the Hoyer lift. On September 16, 2025, at 12:34 p.m., the surveyor noted the facility staffing schedule dated August 2025, did not have a night shift staff member scheduled. O/LALD-A stated that one staff member covered both assisted living houses at night. O/LALD-A stated if assistance was needed using the Hoyer lift during the night shift, that emergency medical services (EMS) would be notified to assist by calling 911. O/LALD-A stated they had not had the need to call 911 for assistance to date. O/LALD-A stated the other resident in the facility was independent with ambulation and did not require assistance. On September 16, 2025, at 1:45 p.m., ULP-C stated the nurse trained her on how to use the Hoyer lift. ULP-C stated she was taught how to clean the equipment and how to apply a Hoyer sling. ULP-C stated she was taught that two people were required to perform transfers using the Hoyer lift. Minnesota Rules 4659.0180, Subpart 5 read "a minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessment and service plan". The licensee's Facility Staffing Plan, undated, indicated, there was to be scheduled on all three shifts every day of the week. In addition, staffing plan indicated the following requirements were	0 470		

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0 470	Continued From page 9 considered for staffing: -individual resident needs and acuity level based on the assessment, service plan, and assisted living contract; -staff ability to respond promptly to scheduled and unscheduled needs of residents and considering the physical layout of the facility with awake staff 24/7; -education, competence, and experience of scheduled staff; -requirements related to missing resident policy; -requirements related to the emergency preparedness plan; and -each resident's acuity level as determined by the most recent assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not	0 480		

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0 480	Continued From page 10 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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 11 Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	0 550		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

(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
0 550	Continued From page 12 Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure to include contact information for the Office of the Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 16, 2025, at 11:14 a.m., during the facility tour, the surveyor observed a lack of the required grievance posting in the common area of the facility. On September 16, 2025, at 11:14 a.m.,	0 550		

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0 550	Continued From page 13 owner/licensed assisted living director (O/LALD)-A stated they knew the grievance procedure was not posted. O/LALD-A stated the ombudsman had recently visited the facility and informed her the posting was required so she was currently "working on it". The licensee's 2.09 Complaint/Grievance policy dated August 1, 202, indicated [licensee] would ensure complaints were resolved in a timely and appropriate manner for residents or employees that have concerns or complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content	0 630		

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0 630	Continued From page 14 for one of two residents (R2). 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 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: R2 was admitted on June 2, 2025, and began receiving assisted living services. R2's Service Plan Modification, unsigned, with an effective date of June 23, 2025, indicated R2's services included assistance with meals, bathing, behavior management, medication administration, and safety checks. R2's IAPP completed by a registered nurse on June 16, 2025, lacked the following required information: -as assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 17, 2025, at 10:27 a.m., clinical nurse supervisor (CNS)-B stated they did not know why the IAPP was missing the required information.	0 630		

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0 630	Continued From page 15 On September 17, 2025, at 10:35 a.m., owner/licensed assisted living director (O/LALD)-A stated the information required in the IAPP had not been addressed during the initial assessment. The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2021, indicated an IAPP would be developed and implemented for each resident and would include the information required by statute. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 16 by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a follow up chest x-ray for one of two employees (unlicensed personnel (ULP)-D). 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 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: The licensee's Facility TB Risk Assessment dated April 3, 2025, identified the facility as a low risk for transmission. ULP-D was hired on April 18, 2025, and began providing assisted living services. ULP-D's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated April 18, 2025, and a positive QuantiFERON TB test May 15, 2025. ULP-D's employee record lacked a chest x-ray to follow up on the positive QuantiFERON TB test. On September 17, 2025, at 12:52 p.m., owner/licensed assisted living director	0 660		

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0 660	Continued From page 17 (O/LALD)-A stated she would contact the provider to locate the missing chest x-ray results. On September 18, 2025, at 1:14 p.m., the surveyor received an email from O/LALD-A indicating ULP-D's chest x-ray results could not be located and they would re-initiate the TB screening process for ULP-D. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated HCW's with a newly positive tuberculin skin test (TST) or interferon gamma-release assay (IGRA (TB blood test)) should have a chest x-ray to rule out infectious TB disease. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated [licensee] would maintain a comprehensive tuberculosis control program consisted with guidelines issued by the CDC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 18 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 19 On September 17, 2025, at 2:00 p.m., owner/licensed assisted living director (O/LALD)-A provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan reviewed and revised February 8, 2025, lacked the following required content: -identification of at-risk population needs like maintaining independence, communication, transportation, supervision, and medical care; -a process for collaboration with local, tribal, regional, State, and Federal EP to maintain an integrated response; -policy and procedures addressing at minimum food, water, and pharmaceutical supplies; -policy and procedures related to sewage and waste disposal; -policies and procedures to track the location of on-duty staff and sheltered residents; -policies and procedures to address safe evacuation from the facility, including consideration of care needs of evacuees, staff responsibilities, identification of evacuation locations, and primary/alternate communication means with external sources of assistance. -policies and procedures to shelter in place for residents, staff, and volunteers who remain in the facility; -policies and procedures to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains the availability of records; -policies and procedures to address the use of volunteers, including the process/role for integration; -copies of arrangement agreements with other facilities identified to receive residents in the	0 680		

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0 680	Continued From page 20 event of evacuation; -policies and procedures to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Social Security Act; -documentation of exercises to test the EP plan at least twice per year, including unannounced staff drills using the EP plan; and -documentation that the missing resident plan had been reviewed quarterly. On September 17, 2025, at 2:30 p.m., O/LALD-A stated they had not updated the plan to include all required content. O/LALD-A stated they were unaware of the content required in the EP plan. O/LALD-A stated they had not reviewed the missing resident plan quarterly as they had not had an incident with a missing resident. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated [licensee]'s EP plan would be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure would be reviewed by the administrator and registered nursing supervisor at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 21 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient conditions have the ability to affect all staff and 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when prob-lems 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 a facility tour on September 17, 2025, between 8:00 a.m. and 10:00 a.m. with the owner/licensed assisted living director (O/LALD)-A, the surveyor observed the following conditions: CIGARETTE BUTTS DISPOSAL: The surveyor observed that many cigarette butts on the ground in front of the garage. No receptacle was provided for the butts/ashes. An approved receptacle shall be provided for the disposal of the cigarette butts/ashes.	0 775		

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0 775	Continued From page 22 ELECTRICAL: The surveyor observed that the cover was missing on the electrical disconnect for the air conditioner unit outside. The cover shall be replaced. SMOKE ALARMS: The surveyor observed that there were 120-volt smoke alarms electrical boxes present in the hallway on the upper-level, in the hallway and both resident rooms in the lower-level. These 120-volt smoke alarms shall be installed and they shall be interconnected to the smoke alarms in the rest of the facility so if ones goes off they all go off. EMERGENCY ESCAPE AND RESCUE WINDOW BLOCKED: The surveyor observed that in resident room 3, the window was blocked by a dresser and TV. This emergency escape and rescue opening (window) shall always be accessible. The deficient conditions were visually verified by O/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 23 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visi-tors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on September 17, 2025, between 8:00 a.m. and 10:00 a.m. with the owner/licensed assisted living director (O/LALD)-A, the surveyor observed the following conditions: WATER DAMAGE/MOLD:	0 800		

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0 800	Continued From page 24 The surveyor observed water stains and mold on the gypsum board in the lower-level resident room 5 and the mechanical room next to it. There were also signs of water leaking through the floor and along the wall in resident room 5. A permit shall be obtained from the Department of Labor and Industry and the Department of Health for any work completed. A qualified contractor shall identify and fix the source of the water intrusion and remove the mold. The deficient conditions were visually verified by O/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 25 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety evacuation training for residents and the fire safety and evacuation plan did not identify the meeting place outside the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious in-jury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or rep-resent a systemic failure that has affected or has the potential to affect a large portion or all of the resi-dents). The findings include:	0 810		

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0 810	Continued From page 26 A record review and interview were conducted on September 17, 2025, at approximately 9:30 a.m. with the owner/licensed assisted living director (O/LALD)-A on the fire safety and evacuation plan training records for the employees and the fire safety and evacuation plan. TRAINING: Training for the residents on the fire safety and evacuation plan was not being conducted. This shall be completed at intake and once a year thereafter for residents. This shall be documented. FIRE SAFETY EVACUATION PLAN: The fire safety evacuation plan did not have a meeting place outside the facility identified. The deficiencies noted above were verified by the O/LALD-A. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

(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
01290	Continued From page 27 section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for one of three employees (registered nurse (RN)-E). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 16, 2025, at 11:54 a.m., owner/licensed assisted living director (O/LALD)-A provided the surveyor with a copy of licensee's employee roster dated September 16, 2025, and a NETStudy roster dated September 16, 2025. RN-E's name was not present on the licensee's employee roster or NETStudy roster. RN-E was issued a registered nursing license by	01290		

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01290	Continued From page 28 the Minnesota Board of Nursing on September 25, 2013. On September 16, 2025, at 12:30 p.m., O/LALD-A stated RN-E was hired on July 25, 2024, to be a back-up nurse for licensee. O/LALD-A stated RN-E was affiliated with another health facility identification (HFID) 37222 owned by the same owner as the licensee and stated they would do the affiliation immediately. A NETStudy Person Summary for RN-E run on September 22, 2025, at 2:39 p.m., indicated RN-E was affiliated with the licensee on September 16, 2025, at 12:32 p.m. (during the survey). The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated [licensee] would conduct a Minnesota Department of Human Services background study on all employees and volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens;	01370		

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01370	Continued From page 29 (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP-C, ULP-D).	01370		

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01370	Continued From page 30 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on July 11, 2025, and began providing assisted living services. ULP-C's employee record included an On-Site Staff Training checklist dated July 14, 2025. The checklist lacked evidence of training/competency in the following areas: -reports of changes in resident's condition to the supervisor designated by the assisted living provider; -maintenance of a safe and clean environment; -care and use of hearing aids; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; and -medication, exercise, and treatment reminders. ULP-D ULP-D was hired on April 18, 2025, and began providing assisted living services. ULP-D's employee record included an On-Site Staff Training checklist dated May 15, 2025. The checklist lacked evidence of training/competency	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 31 in the following areas: -reports of changes in resident's condition to the supervisor designated by the assisted living provider; -maintenance of a safe and clean environment; -care and use of hearing aids; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; and -medication, exercise, and treatment reminders. On September 17, 2025, at 8:58 a.m., owner/licensed assisted living director (O/LALD)-A stated they had created their training and competency documentation forms. On September 17, 2025, at 12:07 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that their training program did not include all required content. CNS-B stated they did not know the required content of training and stated they taught on the content listed on the form. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency would include the following content: -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a safe and clean environment; -care and use of hearing aids; -training on the prevention of falls; -standby techniques and how to perform them; and -medication, exercise, and treatment reminders.	01370		

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01370	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP-C, ULP-D). 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	01380		

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01380	Continued From page 33 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on July 11, 2025, and began providing assisted living services. ULP-C's employee record included an On-Site Staff Training checklist dated July 14, 2025. The checklist lacked evidence of training/competency in the following areas: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. ULP-D ULP-D was hired on April 18, 2025, and began providing assisted living services. ULP-D's employee record included an On-Site Staff Training checklist dated May 15, 2025. The checklist lacked evidence of training/competency in the following areas: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 34 appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On September 17, 2025, at 8:58 a.m., owner/licensed assisted living director (O/LALD)-A stated they had created their training and competency documentation forms. On September 17, 2025, at 12:07 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that their training program did not include all required content. CNS-B stated they did not know the required content of training and stated they taught on the content listed on the form. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency would include the following content: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physician, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01440	Continued From page 35	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of two unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a client's health or	01440		

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01440	Continued From page 36 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired July 11, 2025, and began providing assisted living services. ULP-Cs employee file lacked documentation of direct supervision within 30 days of performing delegated tasks. On September 17, 2025, at 8:05 a.m., ULP-C was observed administering medications to R2. On September 17, 2025, at 12:07 p.m., clinical nurse supervisor (CNS)-B stated they did not know why the 30-day supervision was not completed for ULP-C. On September 17, 2025, at 12:52 p.m., owner/licensed assisted living director (O/LALD)-A stated the 30-day supervision should have been completed by August 13, 2025, and she did not know why it had not been done. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks would be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance.	01440		

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01440	Continued From page 37 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 38 services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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	01470		

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01470	Continued From page 39 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on July 11, 2025, and began providing assisted living services. ULP-C's employee record lacked the documentation of the following required orientation topics: -overview of the Assisted Living statutes; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints (OHFC); -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services (DHS), county managed-care advocates, and other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning and service delivery. ULP-D ULP-D was hired on April 18, 2025, and began providing assisted living services.	01470		

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01470	Continued From page 40 ULP-D's employee record lacked the documentation of the following required orientation topics: -overview of the Assisted Living statutes; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints (OHFC); -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services (DHS), county managed-care advocates, and other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning and service delivery. On September 17, 2025, at 12:52 p.m., owner/licensed assisted living director (O/LALD)-A stated they were unaware that required content was missing from their orientation program. O/LALD-A stated their orientation forms did include all of the required content. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated the following content would be provided for all staff during orientation: -an overview of the appropriate assisted living statutes and rules;	01470		

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01470	Continued From page 41 -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of resident complaints; -consumer advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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01530	Continued From page 42 and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for two of two employees (unlicensed personnel (ULP)-C, ULP-D) 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	01530		

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01530	Continued From page 43 a large portion or all of the residents). The findings include: ULP-C was hired on July 11, 2025, to provide direct care and services to residents. ULP-D was hired April 18, 2025, to provide direct cares and services to residents. On September 17, 2025, at 8:13 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C and ULP-D's employee records lacked training on mental illness and de-escalation. On September 17, 2025, at 12:55 p.m., owner/licensed assisted living director (O/LALD)-A stated they had not provided training to employees on mental health and de-escalation and were not aware of the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based	01640		

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	41007	A. BUILDING: _____ B. WING _____	09/18/2025

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01640	Continued From page 44 on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on June 2, 2025, and began receiving assisted living services. R2's record included a Service Plan effective	01640		

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	41007	A. BUILDING: _____ B. WING _____	09/18/2025

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01640	Continued From page 45 June 23, 2025, indicating R2's services included assistance with bathing, behavior management, medication administration, and safety checks. R2's Service Plan lacked signatures and authentications by the facility and by the resident documenting agreement on the services to be provided. On September 17, 2025, at approximately 10:50 a.m., owner/licensed assisted living director (O/LALD)-A stated they were unaware that R2's service plan lacked signatures. O/LALD-A stated they thought the service plan had been signed. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans and any revisions would include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff	01650		

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	41007	A. BUILDING: _____ B. WING _____	09/18/2025

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01650	Continued From page 46 providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1	01650		

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01650	Continued From page 47 R1 was admitted on March 21, 2025, and began receiving assisted living services. R1's Service Plan signed on March 21, 2025, indicated R1's services included assistance with dressing, grooming, bathing, medication administration, behavior management, and safety checks. R1's service plan lacked the following required information: -the fees for services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring the staff providing services; -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in the resident's condition; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2 was admitted on June 2, 2025, and began receiving assisted living services. R2's unsigned Service Plan effective June 23, 2025, indicated R2's services included assistance with bathing, behavior management, medication administration, and safety checks. R2's service plan lacked the following required content: -the fees for services; -the schedule and methods of monitoring assessments of the resident;	01650		

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	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 48 -the schedule and methods of monitoring the staff providing services; -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in the resident's condition; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On September 17, 2025, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R2. On September 17, 2025, at 10:58 a.m., owner/licensed assisted living director (O/LALD)-A stated they were unaware that service plans lacked required content. O/LALD-A stated they did not know there was required content for service plans. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans would include the following content: -fees for the services to be provided; -a schedule and method for the next planned assessment or monitoring; -a schedule and method for the next planned monitoring of staff providing services; -a contingency plan that includes: -actions [licensee] will take if the service cannot be provided; -the names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 49 change in the resident's condition; -identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and -how the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered per providers orders for two of two residents (R1, R2).	01760		

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01760	Continued From page 50 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on March 21, 2025, and began receiving assisted living services. R1's Service Plan signed on March 21, 2025, indicated R1's services included medication administration. R1's Medication Administration Summary dated September 2025, lacked documentation indicating the following scheduled medication doses had been administered: -levetiracetam (seizure prevention) 250 milligram (mg), five (5) tablets by mouth (po) twice daily to by mouth: September 2, 3, 5, 6, 7, 9, 13, and 14, 2025; -allopurinol (for gout) ten (10) mg po daily: September 3, 6, 7, 9, 13, 24, and 15, 2025; -apixaban (blood thinner) 5 mg po twice daily: September 3, 5, 6, 7, 9, 11, 13, 14, and 15, 2025; -metoprolol (blood pressure) 50 mg po twice daily: September 3, 5, 6, 7, 9, 13, 14, and 15, 2025; -senna (stool softener) 8.6 mg tab po twice daily: September 3, 5, 6, 7, 9, 13, 14, and 15, 2025; -Tylenol (for pain) 325 mg, give two (2) tablets three (3) times daily: September 3, 5, 6, 7, 9, 11,	01760		

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01760	Continued From page 51 13, 14, and 15, 2025; -doxazosin mesylate (for high blood pressure) four (4) mg po at bedtime: September 5, 11, and 14, 2025; and -melatonin 3 mg po at bedtime: September 5, and 14th, 2025. R2 R2 was admitted June 2, 2025, and began receiving assisted living services. R2's Service Plan, unsigned with an effective date of June 23, 2025, indicated R2's services included medication administration. R2's Medication Administration Summary dated September 2025, lacked documentation indicating the following scheduled medication doses had been administered: -amlodipine (for blood pressure) 5 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -aspirin (preventive) 81 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -bupropion (antidepressant) 300 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -citalopram (antidepressant) 20 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025: -isosorbide (prevent chest pain) 30 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -metoprolol 50 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -vitamin C (supplement) 500 mg po daily: September 3, 5, 6, 7, 9, and 13, 2025; -Wegovy (weight loss) 0.5 mg injection, supervised self-administration weekly: September 3, 10 and 17, 2025; -rosuvastatin (for cholesterol) 40 mg po daily: September 5, 7, 10, 11, 12, and 14, 2025; and -trazodone (for sleep) 50 mg po at bedtime:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 52 September 5 and 7, 2025. On September 17, 2025, at 10:46 a.m., the surveyor reviewed the medication summary reports with owner/licensed assisted living director (O/LALD)-A. O/LALD-A stated the staff were not signing off the medications as they were being administered, and they were not sure why. O/LALD-A stated additional training for staff was needed. The licensee's 7.08 Medication Management Administration and Setup policy dated August 1, 2021, indicated documentation of a medication reminder, medication assistance, or medication administration would be completed immediately after the task was performed, medication administration would be documented on the medication administration record (MAR) by entering the ULP's initials under the date opposite the medication and dose given and include the full signature and title of the person who provided the medication administration, ULP would record any problems with medication administration in the MAR including refusals, and ULPs would document any reason why medication administration was not completed as prescribed. No further information was 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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01880	Continued From page 53 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 facility failed to 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 had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 16, 2025, at 10:15 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A stated all residents received medication administration services and medications were kept in a locked file cabinet in the common area. On September 16, 2025, at 11:00 a.m., during the facility tour, the surveyor observed a two-drawer file cabinet in the common area. The surveyor was able to open both drawers of the file cabinet, indicating the cabinet was not locked.	01880		

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01880	Continued From page 54 On September 16, 2025, at 11:00 a.m., O/LALD-A stated the lock on the file cabinet was broken and they were unaware of how long the lock had been broken. O/LALD-A moved all medications to another locked file cabinet in the common area. On September 17, 2025, at 7:36 a.m., the surveyor observed the medication file cabinet had been replaced. The licensee's undated 7.11 Medication Storage policy indicated when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 55 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). 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 number or all the residents. The findings include: R1 was admitted on March 21, 2025, and began	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

(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
01940	Continued From page 56 receiving assisted living services. R1's Service Plan signed on March 21, 2025, indicated R1's services included blood glucose monitoring daily. R1's record lacked a treatment or therapy management plan with all required content. On September 17, 2025, at 10:40 a.m., owner/licensed assisted living director (O/LALD)-A and clinical nursing supervisor (CNS)-B stated they were aware R1 did not have a treatment plan, and they did not know how to create a treatment plan in R-Task (electronic health record). The licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2021, indicated [licensee] would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving mediation assistance or administration and or treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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01960	Continued From page 57 When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted March 21, 2025, and began receiving assisted living services. R1's Service Plan signed March 21, 2025, indicating R1's services included blood glucose monitoring daily. R1's record included a physician order signed July 25, 2025, indicating R1's blood glucose was to be monitored daily. R1's Service Recap Summary log dated September 2025, indicated blood glucose results were not documented on September 2, 3, 5, 6, 7, 9, 13, and 14, 2025.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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01960	Continued From page 58 On September 17, 2025, clinical nurse supervisor (CNS)-B stated they did not know why staff were not documenting treatments and stated the surveyor should ask owner/licensed assisted living director (O/LALD)-A. On September 17, 2025, at 10:50 a.m., O/LALD-A stated they were unaware that staff were not documenting treatments. O/LALD-A stated additional staff training was needed. The licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2021, indicated if medication or treatment assistance or administration were not completed as prescribed, documentation would include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

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PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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03090	Continued From page 59 review, the licensee failed to ensure the required notice included required statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 16, 2025, at approximately 10:00 a.m., upon entering the facility, the surveyor observed the absence of an electronic monitoring notice that included the required statutory language. On September 16, 2025, at 11:00 am, owner/licensed assisted living director (O/LALD)-A stated they were told they did not need to have the required posting if there was no electronic monitoring in the facility. The licensee's 2.15 Electronic Monitoring policy dated August 1, 2021, indicated the licensee would post an electronic monitoring sign at each facility entrance accessible to visitors that stated "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41007	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4756 MARYLAND AVENUE NORTH CRYSTAL, MN 55428

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03090	Continued From page 60 (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

Push Services Inc
4756 Maryland Ave N
Crystal, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41007

Risk:
License:
Expires on:
CFPM: PRINCESS WILSON
CFPM #: 109390; Exp: 1/11/2028

Inspection Info

Report Number: F1023251138
Inspection Type: Full - Single
Date: 9/16/2025 Time: 11:32:47 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

Previous Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: ACQUIRE AND USE SANITIZER TEST STRIPS TO ENSURE PATHOGEN DESTRUCTION.
Comply By: 9/16/2025 Originally Issued On: 9/9/2025

Food & Beverage General Comment

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

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH DURABLE, AND EASILY CLEANABLE. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED AND LEFTOVERS CAN'T BE SAVED
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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

I acknowledge receipt of the Metro District Office inspection report number F1023251138 from 9/16/2025

Gregory T Nelson

PRINCESS WILSON
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Push Services Inc
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F1023251138
Inspection Type: Full
Date: 9/16/2025
Time: 11:32:47 AM

Food Temperature: Product/Item/Unit: MILK; **Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Push Services Inc
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F1023251138
Inspection Type: Full
Date: 9/16/2025
Time: 11:32:47 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 150 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** PPM
Comment:
Violation Issued?: No