Electronically Delivered

October 14, 2025

Licensee
Unique Homes LLC
3940 46th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL37197016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - $500.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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: SL37197016-0 On September 8, 2025, through September 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license. An immediate correction order was issued September 8, 2025, for SL37197016-0 correction tag 0495. During the survey, the licensee took action to mitigate the immediate risk. However, 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.	

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0 330	Continued From page 1	0 330		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (the Department) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the course of the survey from September 8, 2025, through September 10, 2025, the surveyor observed R2 yelling derogatory comments, racial slurs, and profanity. R2 also exhibited signs of aggression as evidenced by	0 330		

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0 330	Continued From page 2 slamming doors, talking under breath, using loud tones, and entering personal space of others. In addition, the surveyor observed a broken entry door to the facility which staff member stated was broken by R2. On September 10, 2025, at 8:14 a.m., registered nurse (RN)-E from R2's previous discharging facility, stated R2 discharged from their facility due to "destroying and breaking everything and refusing to pay rent." RN-E stated they reported to the licensee's nurse upon R2's admission to the licensee that R2 refused his antipsychotic injection and oral medications and would become violent. On September 10, 2025, at 10:12 a.m., clinical nurse supervisor (CNS)-C denied the RN from the previous facility verbalized R2's behaviors during the discharge/admission process and stated the RN just said R2 was non-compliant with medications. On September 10, 2025, at 10:41 a.m., licensed assisted living director (LALD)-D stated they were not aware of R2's behaviors prior to admission. On September 10, 2025, at 10:50 a.m., case worker (CW)-F stated prior to R2's admission to the licensee, the case worker discussed R2's high behaviors with the licensee. CW-F stated the licensee attempted to get a higher rate due to the high behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		

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0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation taken to comply with the correction orders from a survey completed December 2, 2022. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.	0 340		

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0 340	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 24, 2023, the licensee received results from the previous survey concluded on December 2, 2022. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was March 17, 2023. The licensee's correction orders included tag identifier 0680, related to 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. The licensee's undated plan of correction included the following order numbers 0680 and read "we have completed an all-hazard assessment, developed a comprehensive disaster plan including evacuation, shelter-in-place, relocation sites, subsistence needs, tracking of residents/staff, and communication protocols. Exit diagrams were posted, resident received copies, and missing resident policy finalized. Staff and residents completed annual EP [emergency preparedness] training. Systemic Change: EP plan will be reviewed and tested annually through drills." On September 10, 2025, at 3:40 p.m., upon completion of a survey initiated on September 8,	0 340		

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0 340	Continued From page 5 2025, the surveyor found the licensee was still non-compliant with 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. On September 9, 2025, at 8:56 a.m., licensed assisted living director (LALD)-D stated the licensee had made changes to their EPP plan multiple times. LALD-D stated, "I can't get it right. I tried to do it based off the requirement." On September 10, 2025, at 1:52 p.m., the survey inquired how they were implementing the licensee's plan of correction. LALD-D stated, "We are always vigilant with changes with the law, and we visit the findings or tags and see if we can do better documentation on it. We updated our contract and EPP. We are on top of things that way. Physical, somethings they [Minnesota department of health engineer surveyor] pointed out we will start to fix immediately." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly	0 470		

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0 470	Continued From page 6 and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 470		

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0 470	Continued From page 7 The findings include: The licensee's Staffing Plan dated July 1, 2025, indicated one unlicensed personnel (ULP) would be present and one ULP would be on call during the day shift from 7:00 a.m. to 3:00 p.m., evening shift from 3:00 p.m. to 11:00 p.m., and night shift from 11:00 p.m. to 7:00 a.m. An on-call nurse or manager would be available 24 hours per day seven days per week. The staffing plan was signed by clinical nurse supervisor (CNS)-C on July 1, 2025. The Staffing Plan lacked evidence of an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On September 8, 2025, at 2:20 p.m., the surveyor inquired if the licensee had additional documentation for the staffing plan review. LALD-D stated no. LALD-D stated the staffing plan was reviewed once a year and if there was a change that needed to be made with staffing levels. On September 8, 2025, at 2:21 p.m., CNS-C stated they believed the staffing plan needed to be reviewed one time per year and they were unaware of the requirement to review the staffing plan twice per year. The licensee's Staffing Policy & Plan policy dated July 1, 2025, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The staffing plan was based on an evaluation of appropriateness of the staffing levels in the facility and was reviewed at least twice per year.	0 470		

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0 470	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 9 (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: 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).	0 480		

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0 480	Continued From page 10 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 8, 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		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates	0 490		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 490	Continued From page 11 opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, or physical, mental and psychosocial needs for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observations on September 8, 2025, and September 9, 2025, between approximately 8:00 a.m. and 2:30 p.m., the surveyor observed no activities, either planned or offered to residents. The surveyor observed R2 having multiple behaviors, R1 having intermittent, conversations with staff, R3 eating and returning to their room, residents going outdoors to smoke, and residents spending the majority of their day within their rooms. The licensee's September Activities 2025 calendar indicated six days of the month that included an activity.	0 490		

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0 490	Continued From page 12 R1 R1 admitted the licensee on July 5, 2025, and began receiving assisted living services. R1's service plan signed August 6, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". R2 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R3 R3 admitted to the licensee on October 12, 2022, and began receiving assisted living services. R3's record included a "24-hour Customized Living Services- Daily" form dated October 12, 2022. The form indicated R3 received services including assistance with dressing, grooming, bathing, medication reminders, assistance with self-administration of medications, and behavior management.	0 490		

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0 490	Continued From page 13 R1, R2, R3's records lacked an activity plan per the licensee's Outing and Activities policy. On September 10, 2025, at 10:34 a.m., housing manager (HM)-A stated the licensee takes the residents to the buffet, they have a gaming council and play dominos for activities. HM-A stated they do outings two or three times per month. The surveyor inquired if they provide an activity for the resident's daily. HM-A stated they provide 1:1 conversation with residents. The surveyor inquired how they would know what activities to offer. HM-A stated the residents were asked upon admission what they like to do and there was an activities calendar. HM-A stated if there was no activity written on the calendar, they will offer to do something with the resident based on their preference and it was the resident's choice if they wanted to do it or not. On September 10, 2025, at 1:56 p.m., licensed assisted living director (LALD)-D stated activities were customizable to each resident. LALD-D stated at one point the licensee planned an outing once per week however it was difficult to get residents to agree so if a resident requests an outing the licensee plans that outing. The surveyor inquired if they had something to show the ULP what activity to offer and something to notify a resident what activity would be offered each day. LALD-D stated, "there should be one, but I don't think we have it planned once per day." The licensee's Outing and Activities policy dated August 1, 2021, indicated each resident would have their own activity schedule that reflects their unique preferences and interests, physical and metal capabilities, health care needs, and cultural	0 490		

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0 490	Continued From page 14 and religious practice. The activity plans would be reviewed and updated as part of the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. 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: The licensee held a current assisted living facility license valid until June 30, 2026. R1 R1 admitted the licensee on July 5, 2025, and	0 495		

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0 495	Continued From page 15 began receiving assisted living services. R1's diagnoses included anxiety and depression. R1's service plan signed August 6, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". On September 8, 2025, at approximately 9:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated R1 received services including assistance with medication administration. R2 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination) and depression. R2's unsigned and undated service plan indicated R2 received services including assistance with medication set up and administration, and behavior management. R3 R3 admitted to the licensee on October 12, 2022, and began receiving assisted living services. R3's diagnoses included anxiety and depression. R3's record included a "24-hour Customized Living Services- Daily" form dated October 12, 2022. The form indicated R3 received services including assistance with dressing, grooming,	0 495		

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0 495	Continued From page 16 bathing, medication reminders, assistance with self-administration of medications, and behavior management. R4 R4 admitted to the licensee on October 31, 2025, and began receiving assisted living services. R4's diagnoses included anxiety and depression. R4's care plan dated November 2, 2024, indicated R4 received services including verbal reminders for bathing and grooming, behavior management, housekeeping, medication refills, appointments, and shopping. On September 8, 2025, at 9:48 a.m., during the entrance conference, CNS-C stated they were the only nurse who worked for the licensee. CNS-C stated they worked part-time 48 hours every two weeks at a hospital. CNS-C stated their hospital duties included providing direct patient care. CNS-C stated they worked mainly the weekends. CNS-C stated they were unable to answer telephone calls when in the rooms with patients however, they would check their cell phone when they exited rooms and when they were on breaks, and could return messages then. CNS-C stated they could leave their hospital shift in an emergency because the hospital had emergency backup nurses that could take over their case load of patients so they could leave. CNS-C stated if they were not able to answer their phone immediately, they have trained the unlicensed personnel (ULP) to call 911 in the event of an emergency. On September 8, 2025, at 1:44 p.m., housing manager (HM)-A stated they have not had to	0 495		

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0 495	Continued From page 17 contact the nurse for any emergencies at the facility. HM-A stated they did contact the nurse to update them on appointments and had not had any issue getting ahold of the RN. The licensee's 6.2 Availability of an RN for Staff policy dated August 1, 2021, indicated the RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff was providing services. The on-call licensed health professional shall respond and provide consultation to the ULP in a timely manner based on the communicated information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate R2's admission date was amended after the initial immediate order went to the licensee due to further information provided by the licensee.	0 495		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 18 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of four employees (housing manager (HM)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 9, 2025, at 8:12 a.m., the surveyor observed HM-A perform hand hygiene and apply a pair of gloves. HM-A performed medication administration for R1, removed gloves, locked the medication closet, and then threw the gloves away in the trash. Without performing hand hygiene, HM-A opened a kitchen cabinet, grabbed a pen from the living room, shut the kitchen cabinet, drank a liquid from a water bottle, retrieved a recently delivered medication from the living room, placed a phone call to the nurse related to medication delivery, opened the delivery packet to review its contents, took a photo of the delivery content and sent it to the nurse, answered the nurse's return phone call, placed a dirty pot into the kitchen sink, ran the kitchen water, cued R1 to eat, provided the surveyor with an employee record, and began	0 510		

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0 510	Continued From page 19 typing on the computer in the living room. The surveyor inquired how they were trained on infection control. HM-A stated they completed a course on EduCare (a training software) and then they completed a training and demonstration with the nurse. HM-A stated they were trained to complete hand hygiene before and after food preparation, before and after medication administration, and after glove removal. HM-A stated they performed hand hygiene every 15 to 30 minutes because they are touching "stuff". HM-A stated, "When I put the pot in the sink, I think it slipped my mind to wash my hands." On September 9, 2025, at 11:36 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained on infection control and hand hygiene upon hire and then monthly. The Centers for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended to clean your hands: - immediately before touching a patient; - before performing an aseptic task such as placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's Infection Prevention & Control Program (144G) policy dated January 1, 2025, indicated the program was designed to comply with Minnesota Rule 144G and CDC guidelines.	0 510		

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0 510	Continued From page 20 In addition, Staff were trained and monitored on hand hygiene compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=H	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 observation, interview, and record review, the licensee failed to have an accurate individual abuse prevention plan (IAPP) for two of three residents (R2, R3) and failed to have statement of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for one of three residents (R2). 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),	0 630		

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0 630	Continued From page 21 and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's Individual Abuse Prevention Plan Assessment dated August 26, 2025, indicated R2 was susceptible to abuse from another individual including other vulnerable adults and was not at risk for abusing other vulnerable adults. R2's initial assessment dated August 26, 2025,	0 630		

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0 630	Continued From page 22 read, "client [R2] displayed irritability and raised voice toward staff, using verbally abusive language." The assessment indicated R2 presented with a hostile and defensive demeanor, paced the room, had tense body language, and tone and words were threatening to staff. R2's progress note dated September 3, 2025, indicated R2 was verbally abusive, "yelling profanities and making hostile remarks", "[R2] was observed pacing in the hallway with clenched fists, a tense facial expressions, and an elevated tone of voice", and "Other residents in the area were moved for safety." R2's Incident Report dated September 7, 2025, indicated R2 threw multiple kitchen utensils and cereal boxes in the direction of staff. Housing manager (HM)-A attempted to de-escalate the situation by using calm and clear communication however, the situation continued to escalate. "Due to safety concerns for both staff and other residents in the facility, staff contacted local law enforcement immediately." In addition, the incident report indicated R2's case manager would be contacted to discuss resident placement concerns and behaviors. On September 8, 2025, at 10:17 a.m., the surveyor observed R2 at the top of the stairway using racial slurs and profanity, in a loud tone. On September 9, 2025, at 9:43 a.m., the surveyor observed R2 yelling about vitamin D3. R2 paced the facility's main level, entering staff member's personal space, yelling derogatory comments and using profanity towards staff members. HM-A and clinical nurse supervisor	0 630		

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0 630	Continued From page 23 (CNS)-C attempted to discuss R2's medication with them however the situation continued to escalate until the surveyor asked a question related to the resident's Vitamin D3. At that time R2 exited the living space and went near the stairwell. On September 9, 2025, at 11:49 a.m., CNS-C stated they did not complete a preadmission assessment on R2. CNS-C stated the staff redirect residents with behaviors and attempts to get residents back on their medications when they admit to their facility to decrease the resident's behaviors. On September 9, 2025, at 1:39 p.m., the surveyor observed R2 moving items from the lower level of the facility out the front door for over 20 minutes. R2 showed signs of aggression by slamming doors, talking under their breath, and using loud tones when commenting on staff. The surveyor did not see any of the staff intervene or attempt to deescalate R2. On September 9, 2025, at 2:29 p.m., licensed assisted living director (LALD)-D stated they believed R2 took their belongings to a different ALF. On September 10, 2025, at 8:14 a.m., registered nurse (RN)-E from R2's previous discharging facility, stated R2 discharged from their facility due to "destroying and breaking everything and refusing to pay rent." RN-E stated they reported to the licensee's nurse upon R2's admission to the licensee that R2 refused his antipsychotic injection and oral medications and would become violent.	0 630		

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0 630	Continued From page 24 On September 10, 2025, at 10:07 a.m., HM-A stated for behavioral interventions for R2 they used redirection, and if R2 was following staff they would ask R2 to stop, or staff would walk outside until R2 had calmed down. In addition, HM-A stated they would try to get R2 to walk their dog to calm down. HM-A stated it depended on the situation what they would use to deescalate the situation. HM-A stated they were trained on general behavioral management interventions like redirection or to remove themself from a situation or to call for help. HM-A stated there were no written individualized interventions for R2 that they had seen however, directed the surveyor to ask the nurse. HM-A stated they had called 911 "five or six times" due to R2's behaviors. On September 10, 2025, at 10:12 a.m., CNS-C denied the RN from the previous facility verbalized R2's behaviors during the discharge/admission process and stated the RN just said R2 was non-compliant with medications. CNS-C stated R2 was angry, swearing at people, and was unwilling to complete an assessment upon admission. The surveyor inquired what interventions were put into place when they found out R2 had aggressive behaviors. CNS-C state the licensee had general behavioral interventions that they used on any resident when they admit. CNS-C stated they teach all staff the interventions to teach them how to protect themselves from being attacked and how to keep the resident safe. CNS-C stated they were creating a behavior plan for R2, but they had not printed it out yet or put it in R2's chart and it had not been implemented. CNS-C stated the unlicensed personnel (ULP) did not have access to the document. The document was	0 630		

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0 630	Continued From page 25 titled Individual Behavior Plan and included multiple interventions for R2's behaviors. CNS-C stated they did talk with ULP to talk with R2 in a calm polite manner and to find an exit door so not one would get hurt. CNS-C stated if R2's behaviors continued the ULP should call 911. CNS-C stated they believed 911 had been called once or twice for R2. On September 10, 2025, at 10:22 a.m., the surveyor inquired why R2's IAPP indicated they were not at risk to abuse others. CNS-C stated, "because it was my first encounter with him." The surveyor inquired why the IAPP was not updated. CNS-C stated because R2 had not had their 14-day assessment, and it would have been updated at the time the 14-day assessment was conducted. CNS-C stated IAPPs were updated with assessments and with change of condition assessments. On September 10, 2025, at 10:41 a.m., LALD-D stated their process prior to an admission was that a prospective resident's case worker would provide them with information related to the resident's needs and behaviors. LALD-D stated they were not aware of R2's behaviors prior to admission. On September 10, 2025, at 10:50 a.m., case worker (CW)-F stated prior to R2's admission to the licensee the case worker discussed R2's high behaviors with the licensee. CW-F stated the licensee attempted to get a higher rate due to the high behaviors. On September 10, 2025, at 11:23 a.m., LALD-D stated R2 admitted to another assisted living facility last evening and that the new facility's staff	0 630		

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0 630	Continued From page 26 members were coming to get R2's belongings. On September 10, 2025, at 2:27 p.m., CNS-C stated R2 discharged from the facility to another licensee at approximately 11:45 a.m., on September 10, 2025. CNS-C provided R2's medications to the new facility's staff overseeing R2's care. Although R2 had an IAPP, the licensee failed to update the plan once they learned about R2's threat to other individuals. The licensee also failed to implement individualized interventions to deescalate R2's behaviors. In addition, the licensee's staff members were not properly trained on mental health and de-escalation techniques per MN Statute 144G.63 Subd. 4. Training required relating to dementia, mental illness, and de-escalation, see tag identifier 1530. R3 R3 admitted to the licensee on October 12, 2022, and began receiving assisted living services. R3's diagnoses included anxiety and depression. R3's record included a "24-hour Customized Living Services- Daily" form dated October 12, 2022. The form indicated R3 received services including assistance with dressing, grooming, bathing, medication reminders, assistance with self-administration of medications, and behavior management. R3's undated Customized Living Preliminary Behavior Plan indicated R3 had a history of verbal aggressive behavior, characterized by name-calling. When R3 name-called, it could create a hostile and uncomfortable environment	0 630		

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0 630	Continued From page 27 to individuals around them. The behavior plan listed interventions related to R3's behaviors. R3's IAPP dated July 7, 2025, indicated R3 was susceptible to abuse from other individuals and R3 was not at risk for abusing other vulnerable adults. Although R3's record contained an IAPP, the licensee failed to update the IAPP to reflect R3's risk of abusing other vulnerable adults. The licensee's Abuse Prevention Policy dated August 1, 2021, outlined measures for prevention, detection, reporting, and response, in accordance with the Minnesota Vulnerable Adults Act and the Minnesota Department of Health (MDH) for assisted living providers. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650		

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0 650	Continued From page 28 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (housing manager (HM)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HM-A was hired on October 25, 2022, to provide assisted living services to residents. HM-A's employee record lacked the following required content: - annual training of the licensee's policies and procedures.	0 650		

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0 650	Continued From page 29 On September 9, 2025, at 12:57 p.m., licensed assisted living director (LALD)-D stated the licensee reviewed their policies and procedures with staff members annually. LALD-D stated the licensee reviewed the policies, showed staff where to find the policies, and told staff who to contact if they had further questions. LALD-D stated they completed the education of policies and procedures with all staff however, they did not document the review. HM-A entered the living room and stated they received training on the policies and procedures of the licensee. The licensee's Annual Training Policy dated August 1, 2021, indicated all annual training would be completed by December 31 each calendar year. In addition, completion of annual training would be documented with staff signatures, training materials, and competency checklist and would be kept in the employee file for a minimum of five years. Training logs would be available to the Minnesota Department of Health (MDH) upon request. The licensee's Content of Employee Records policy dated August 21, 2021, indicated an employee record shall include ongoing and annual training records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 30 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 31 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan reviewed January 25, 2025, lacked evidence of the following required content: - consideration of emerging infectious disease; - facility risk assessment; - quarterly review of the missing resident plan; - transportation; - medical and pharmaceutical supplies; - sewage and waste disposal; and - residents physicians contact numbers. On September 9, 2025, at 8:56 a.m., licensed assisted living director (LALD)-D stated they did not have a facility risk assessment that encountered all disasters. LALD-D stated for transportation the licensee would use another licensee's van in addition to theirs to transport residents in an evacuation. LALD-D stated they did not have that in writing. LALD-D stated for medical supplies and pharmaceutical supplies the staff members would just grab what was on hand at the facility. LALD-D stated the resident face sheet would have the provider's contact information and the face sheet would be taken with in case of an emergency. The surveyor observed R1 and R2's face sheet and showed LALD-D neither face sheet had the provider's numbers or names listed. LALD-D stated they missed creating a sewage and waste disposal plan. LALD-D stated they reviewed the missing resident plan twice per year. The licensee's Emergency Preparedness Policy	0 680		

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0 680	Continued From page 32 dated August 1, 2025, indicated the licensee maintained a comprehensive EPP to ensure the safety, health, and continuity of care for residents, staff, and visitors during emergencies and disasters. The program was based on an all-hazard approach and complies with Minnesota Statutes, Chapter 144G, MDH regulations, and applicable federal guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the provisions of Minnesota State Fire Code under MN Rules chapter 7511. This deficient condition had 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 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).	0 775		

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0 775	Continued From page 33 The findings include: September 10, 2025, at approximately 11:00 a.m., survey staff toured the facility with program director (A)-B. The following was observed. In bedroom 1 a three-way plug was plugged into an extension cord creating a fire hazard. On September 10, 2025, A-B acknowledged the deficiency while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 34 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions had 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 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 10, 2025, at approximately 11:00 a.m., survey staff toured the facility with program director (A)-B. During the tour, the surveyor observed there was no smoke alarm in the immediate vicinity outside of the main level sleeping rooms. On September 10, 2025, during the facility tour A-B, stated they would move the smoke alarm from the kitchen area and install the smoke alarm in the immediate vicinity outside of the main level bedrooms.	0 780		

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0 780	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 36 September 10, 2025, at approximately 11:00 a.m., survey staff toured the facility with program director (A)-B. The following was observed. GENERAL MAINTENANCE: The lower-level rear exit door had glass was broken and shards still in the door. This has the potential to injury staff and residents. The screen was ripped out of the frame in bedroom 4. Damaged or missing screens in doors and windows can serve as access points to pests and rodents. On September 10, 2025, A-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 37 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 38 On September 10, 2025, program director (A)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On September 10, 2025, A-B stated they understood the requirements for training residents and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must:	0 900		

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0 900	Continued From page 39 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of three 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:	0 900		

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	37197	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

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0 900	Continued From page 40 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's record included an undated Assisted Living Contract, which was not signed by R2 or by a staff member of the licensee. R2's progress notes dated August 26, 2025, through September 3, 2025, did not include documentation related to the licensee's attempts to obtain a signature by R2 or R2's responsible party. On September 10, 2025, at 10:39 a.m., in an interview with clinical nurse supervisor (CNS)-C, housing manager (HM)-A, and licensed assisted living director (LALD)-D, CNS-C stated they were not responsible for contracts being signed. LALD-D stated per the rule, the licensee had two days to get the contract signed. LALD-D stated due to R2's behaviors they were unable to get R2 to agree to sign the contract. LALD-D stated they attempted to get R2 to sign the contract the first couple days and then instructed HM-A to attempt to obtain a signature. HM-A stated they had	0 900		

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0 900	Continued From page 41 attempted to get R2 to sign the contract since they arrived at least five times. The surveyor inquired if they had documentation of the attempts. LALD-D stated they had the documentation "somewhere" and would provide it to the surveyor. Upon completion of the survey, the surveyor did not receive further documentation on attempts the licensee made to gain a signature from R2 for the contract. The licensee's Assisted Living Contract Policy dated August 1, 2021, indicated the assisted living contract must be provided to the resident or resident repetitive at least five days before move-in, unless waived in writing. The Contract must be signed before any services were delivered and a copy of the signed contract must be given to resident or representative and maintained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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	01530		

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01530	Continued From page 42 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 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 interview and record review, the license failed to ensure employees completed two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for two of two employees (housing manager (HM)-A, clinical nurse supervisor	01530		

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01530	Continued From page 43 (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: HM-A HM-A was hired on October 25, 2022, to provide assisted living services to residents. HM-A's record included a half hour of mental health training completed September 18, 2024. HM-A's employee record lacked 1.5 hours of mental health and de-escalation required training. CNS-C CNS-C was hired on February 22, 2024, to provide oversite to unlicensed personnel and assisted living services to residents. CNS-C's record included a half hour of mental health training January 12, 2024. CNS-C lacked 1.5 hours of mental health and de-escalation required training. On September 9, 2025, at 9:26 a.m., licensed assisted living director (LALD)-D stated per their policy, mental health and de-escalation training needed to be completed by December 31, 2025. LALD-D stated the courses were assigned to all	01530		

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01530	Continued From page 44 staff members in EduCare (a documenting software company) and the employees had until the end of the year to complete the courses. LALD-D stated they misunderstood the requirement for when the training needed to be completed by. The surveyor inquired how many people still needed to receive the training. Housing manager (HM)-A entered the conversation and stated they still needed to receive one course, and the nurse needed to receive the course as well. The surveyor asked LALD-D and HM-A to provide the number of the licensee's staff who had received training and number that had not received training. On September 9, 2025, at 1:16 p.m., the surveyor again inquired out of the six employees the licensee employed how many still needed to complete the mental health required trainings. LALD-D told the surveyor they would provide the information. Upon completion of the survey on September 10, 2025, at 2:40 p.m., the surveyor had not received the number of employees that still needed to complete the mental health training. The licensee's Annual Training policy dated August 1, 2021, indicated annual training for dementia and mental health training was based on staff role per Minnesota Statue 144G.64. Annual trainings must be completed by December 31st of each year. This policy and the licensee's other training and orientation policies did not address the initial training on mental health and de-escalation. No further information was provided.	01530		

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01530	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01600 SS=F	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had staff, sufficient in numbers, training, and qualifications to adequately provide the agreed upon services. Although the facility was aware of R2's behaviors prior to admission, they did not ensure staff were properly trained or implement a behavioral management plan. This had the potential to harm all residents and staff of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services.	01600		

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01600	Continued From page 46 R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's initial assessment dated August 26, 2025, read, "client [R2] displayed irritability and raised voice toward staff, using verbally abusive language." The assessment indicated R2 presented with a hostile and defensive demeanor, paced the room, had tense body language, and tone and words were threatening to staff. R2's progress note dated September 3, 2025, indicated R2 was verbally abusive, "yelling profanities and making hostile remarks", "[R2] was observed pacing in the hallway with clenched fists, a tense facial expressions, and an elevated tone of voice", and "Other residents in the area were moved for safety." R2's Incident Report dated September 7, 2025, indicated R2 threw multiple kitchen utensils and	01600		

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01600	Continued From page 47 cereal boxes in the direction of staff. Housing manager (HM)-A attempted to de-escalate the situation by using calm and clear communication however, the situation continued to escalate. "Due to safety concerns for both staff and other residents in the facility, staff contacted local law enforcement immediately." In addition, the incident report indicated R2's case manager would be contacted to discuss resident placement concerns and behaviors. On September 8, 2025, at 10:17 a.m., the surveyor observed R2 at the top of the stairway using racial slurs and profanity, in a loud tone. On September 9, 2025, at 9:43 a.m., the surveyor observed R2 yelling about vitamin D3. R2 paced the facility's main level, entering staff members personal space, yelling derogatory comments and using profanity towards staff members. HM-A and clinical nurse supervisor (CNS)-C attempted to discuss R2's medication with them however the situation continued to escalate until the surveyor asked a question related to the resident's Vitamin D3. At that time the resident exited the living space and went near the stairwell. On September 9, 2025, at 11:49 a.m., CNS-C stated they did not complete a preadmission assessment on R2. CNS-C stated the staff redirect behavioral residents and try to get them back on medications when they admit to their facility. On September 9, 2025, at 1:39 p.m., the surveyor observed R2 moving items from the lower level of the facility out the front door for over 20 minutes. R2 was showing signs of	01600		

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01600	Continued From page 48 aggression by slamming doors, talking under their breath, and using loud tones when commenting on staff. The surveyor did not see any of the staff intervene or attempt to deescalate R2. On September 10, 2025, at 8:14 a.m., registered nurse (RN)-E from R2's previous discharging facility, stated R2 discharged from their facility due to "destroying and breaking everything and refusing to pay rent." RN-E stated they reported to the licensee's nurse upon R2's discharge that R2 refused his antipsychotic injection and oral medications and would become violent. On September 10, 2025, at 10:07 a.m., HM-A stated for behavioral interventions for R2 they used redirection, and if R2 was following them they would ask R2 to stop or walk outside until R2 had calmed down. In addition, HM-A stated they would try to get R2 to walk their dog to calm down. HM-A stated it depended on the situation what they would use to deescalate the situation. HM-A stated they were trained on general behavioral management interventions like redirection or to remove themself from a situation or to call for help. HM-A stated there were no written individualized interventions for R2 that they had seen but the surveyor should ask the nurse. HM-A stated they had called 911 "five or six times" due to R2's behaviors. On September 10, 2025, at 10:12 a.m., CNS-C stated R2 was angry, swearing at people, and was unwilling to complete an assessment upon admission. The surveyor inquired what interventions were put into place when they found out R2 had aggressive behaviors. CNS-C state the licensee had general behavioral	01600		

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01600	Continued From page 49 interventions that they used on any resident when they admit. CNS-C stated they teach all staff the interventions to teach them how to protect themselves from being attacked and how to keep the resident safe. CNS-C stated they were creating a behavior plan for R2, but they had not printed it out yet or put it in R2's chart and it had not been implemented. CNS-C stated the unlicensed personnel (ULP) did not have access to the document. The document was titled Individual Behavior Plan and included multiple interventions for R2's behaviors. CNS-C stated they did talk with ULP to talk with R2 in a calm polite manner and to find an exit door so not one would get hurt. CNS-C stated if R2's behaviors continued the ULP should call 911. CNS-C stated they believed 911 had been called once or twice for R2. On September 10, 2025, at 10:41 a.m., licensed assisted lining director (LALD)-D stated their process prior to an admission was that a prospective resident's case worker would provide them with information related to the resident's needs and behaviors. LALD-D stated they were not aware of R2's behaviors prior to admission. On September 10, 2025, at 10:50 a.m., case worker (CW)-F stated prior to R2's admission to the licensee the case worker discussed R2's high behaviors. CW-F stated the licensee attempted to get a higher rate due to the high behaviors. On September 10, 2025, at 11:23 a.m., LALD-D stated R2 admitted to another assisted living facility last evening and that the new facility's staff members were coming to get R2's belongings. On September 10, 2025, at 2:27 p.m., CNS-C	01600		

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01600	Continued From page 50 stated R2 discharged from the facility to another licensee at approximately 11:45 a.m., on September 10, 2025. The licensee accepted R2 to their facility knowing R2 had mental health conditions with physical and verbal behaviors and did not ensure their staff completed appropriate training related to mental health and de-escalation (see tag identifier 1530). In addition, the licensee failed to implement behavioral interventions as directed by the service plan for R2 which was likely a contributing factor to unresolved behaviors R2 experienced at the facility, a number of 911 phone calls during R2's stay at the facility, disruption to other residents residing at the facility, and R2's discharge from the facility 15 days after their admission. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01600		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective	01620		

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01620	Continued From page 51 resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 52 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of three residents (R3). In addition, the licensee failed to complete an accurate assessment related to resident's activities of daily living (ADL) needs for one of three 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LATE ASSESSMENT R3 admitted to the licensee on October 12, 2022, and began receiving assisted living services. R3's diagnoses included anxiety and depression. R3's Service Plan dated January 9, 2025, indicated, "see exhibit 1 for level of care and charges". R3's Service Plan lacked "exhibit 1". R3's record included a "24-hour Customized Living Services- Daily" form dated October 12, 2022. The form indicated R3 received services including assistance with dressing, grooming, bathing, medication reminders, assistance with self-administration of medications, and behavior	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 53 management. R3's record included 90-day ongoing assessments dated March 6, 2025, and July 7, 2025, which indicated 123 days passed between the two assessments. R3's next assessment was due on or before June 4, 2025. On September 10, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated R3 was not "around during the time of assessment or did not want to do the assessment." The surveyor inquired if there was documentation of attempts to complete the assessment prior to June 4, 2025. CNS-C provided four progress notes titled June Notes dated June 5, 2025, through June 21, 2025, which indicated on June 21, 2025, R3 had their granddaughter visiting in their room, an unknown person (due to progress notes not having signature or names) attempted to complete an assessment but R3 did not answer when asked. CNS-C stated they attempted to complete the assessment more than three times. Although CNS-C attempted to complete R3's assessment on June 21, 2025, there was no evidence to suggest any attempts were made to complete the assessment prior to June 4, 2025, or between June 4, 2025, and June 21, 2025, or between June 21, 2025, and July 7, 2025, when the next assessment was completed. INACCURATE ASSESSMENT R1 admitted the licensee on July 5, 2025, and began receiving assisted living services. R1's diagnoses included anxiety and depression. R1's service plan signed August 6, 2025,	01620		

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	37197	A. BUILDING: _____ B. WING _____	09/10/2025

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01620	Continued From page 54 indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". R1's Nursing Care Plan dated July 10, 2025, indicated R1 was independent with bathing, dressing, grooming, toileting, mobility, and feeding. R1's 14-day assessment dated July 24, 2025, indicated R1 was independent with ambulation, transfers, bed mobility, eating, grooming, dressing, and bathing. R1 did not need cues or reminders or staff assistance for the activities of daily living (ADLs) listed above. R1's unlicensed personnel (ULP) task service checks off list dated September 2025 included ADL support for dressing, grooming, and bathing. The service was documented on the 7:00 a.m. to 3:00 p.m. shift, 3:00 p.m. to 11:00 p.m. shift, and 11:00 p.m. to 7:00 a.m. shift. The service was marked as being completed daily from September 1 to September 8, 2025, on the day shift. The service was marked as being completed three times and refused four times on the evening shift from September 1 to September 8, 2025. The service was marked as being completed four times and refused four times on the overnight shift from September 1 to September 8, 2025. On September 10, 2025, at 2:08 p.m., CNS-C stated they set up the ULP service checkoff based on resident's needs. CNS-C stated R1 required verbal cues for ADL's. CNS-C stated they mismarked the assessment. The licensee's Client Assessment Policy dated August 1, 2021, indicated the licensee conducted	01620		

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01620	Continued From page 55 their resident assessments prior to or at the time the services begin, within 14 calendar days after the service, at least every 90 calendar days thereafter, and when there was a significant change of condition. In addition, the 14-day comprehensive assessment would address functional abilities such as activities of daily living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 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	01640		

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01640	Continued From page 56 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for one of three 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 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and	01640		

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01640	Continued From page 57 administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's progress notes dated August 26, 2025, through September 3, 2025, did not include documentation related to attempts made by the licensee to get the service plan signed. On September 10, 2025, at 10:39 a.m., in an interview with clinical nurse supervisor (CNS)-C, housing manager (HM)-A, and licensed assisted living director (LALD)-D, CNS-C stated they were not responsible for the service plan being signed. LALD-D stated due to R2's behaviors they were unable to get R2 to agree to sign the service plan. LALD-D stated they attempted to get R2 to sign the service plan the first couple days and then instructed HM-A to attempt to obtain a signature. HM-A stated they had attempted to get R2 to sign the service plan since they arrived at the facility and had attempted at least five times. The surveyor inquired if they had documentation of the attempts. LALD-D stated they have the documentation "somewhere" and would provide it to the surveyor. Upon completion of the survey, the surveyor did not receive further documentation on attempts the licensee made to gain a signature from R2 for the service plan. The licensee's Service Plan Policy dated August 1, 2021, indicated service plans reflected resident needs, preferences, and professional recommendations, and they must contain all elements required under Minnesota Statues chapter 144G. The service plan and updated	01640		

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01640	Continued From page 58 must be signed and dated by the resident and/or resident representative and facility staff. 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 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.	01650		

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01650	Continued From page 59 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 all required content for three of three residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted the licensee on July 5, 2025, and began receiving assisted living services. R1's diagnoses included anxiety and depression. On September 9, 2025, at 8:12 a.m., the surveyor observed housing manager (HM)-A provide medication administration to R1. R1's Individualized Medication Management Plan Sample Form dated July 10, 2025, indicated R1 received medication administration from the licensee's staff members. R1's Nursing Care Plan dated August 9, 2025, indicated R1 was independent with bathing, dressing, grooming, toileting, mobility, and feeding. In addition, R1 would be encouraged to	01650		

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01650	Continued From page 60 verbalized feelings, thoughts, and concerns in a safe nonjudgmental environment, staff to accompany R1 to appointments. R1's service check off list indicated R1 received assistance with homemaking, shopping, meal preparation, appointments, support with dressing, grooming, bathing, medication management, safety checks related to smoking, and behavior management three times per day once during each shift. R1's service plan signed August 6, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". R1's service plan lacked the following required content: - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services. R3 R3 admitted to the licensee on October 12, 2022, and began receiving assisted living services. R3's diagnoses included anxiety and depression. R3's record included a "24-hour Customized Living Services- Daily" form dated October 12, 2022. The form indicated R3 received services including assistance with dressing, grooming, bathing, medication reminders, assistance with self-administration of medications, and behavior management. R3's Service Plan dated January 9, 2025, indicated, "see exhibit 1 for level of care and charges". R3's Service Plan lacked "exhibit 1".	01650		

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01650	Continued From page 61 R3's service plan lacked the following required content: - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services. R4 R4 admitted to the licensee on October 31, 2025, and began receiving assisted living services. R4's diagnoses included anxiety and depression. R4's care plan dated November 2, 2024, indicated R4 received services including verbal reminders for bathing and grooming, behavior management, housekeeping, medication refills, appointments, and shopping. R4's Service Plan dated January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R4's Service Plan lacked "exhibit 1". R4's service plan lacked the following required content: - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services. On September 8, 2025, at 12:46 p.m., licensed assisted living director (LALD)-D stated R1 and R4's service plan lacked the above content because the licensee was waiting on the county for approval of services and payment. On September 8, 2025, at 12:56 p.m., LALD-D stated staff used the care plan to know what services to provide until the rate came in from the county. LALD-D stated the licensee typically	01650		

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01650	Continued From page 62 attached the services and rates of services once the information was received from the county to the service plan. LALD-D stated R3's 24-hour Customized Living Services-Daily was what they attach to the service plan once received from the county. The licensee's Service Plan Policy dated August 1, 2021, read, "Each service plan must include, at minimum: - Resident demographics and emergency contact information. - Contingency plan outlining how services will continue if normal staffing, resources, or systems are disrupted (e.g., during emergencies or evacuations). - Resident goals, strengths, and preferences. - Description of each service provided, including frequency, duration, and staff responsible. - Provider contact information, including physicians, pharmacies, therapists, and other relevant healthcare professionals. - Fees for each service, consistent with the resident's contract and billing practices. - Medication management services (if applicable). - Treatments, therapies, or delegated nursing tasks (if applicable). - Risk factors, safety interventions, and any specialized care needs. - Documentation of resident choice, including the right to refuse care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01700	Continued From page 63	01700		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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) conducted an accurate face-to-face medication management assessment to include all required content, prior to providing medication management services,	01700		

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01700	Continued From page 64 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 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. On September 9, 2025, at 9:50 a.m., the surveyor observed housing manager (HM)-A and	01700		

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01700	Continued From page 65 clinical nurse supervisor (CNS)-C enter the medication closet attempted to provide medication to R2. R2 did not receive any medication from the staff members because R2 refused the medication that was being offered and was only requesting a specific medication. R2's medication administration record (MAR) dated August 1, 2025, through August 30, 2025, included the following medications: benztropine mesylate 1 milligram (mg) twice per day, cetirizine hydrochloride 10 mg daily, ciclopirox solution apply to affected area daily, famotidine 20 mg daily, fluphenazine decanoate 25 mg injected intramuscularly every three weeks, omeprazole 20 mg daily, Systane 0.6 percent (%) solution one drop in both ears twice a day, vitamin D3 25 micrograms (mcg) daily. The medications had an arrow through the administration signature spaces through August 28, which indicated medications were starting on August 29, 2025, for all scheduled medications. R2's as needed (PRN) medications were left blank with no documentation or arrows. R2's progress notes dated August 26, 2025, through September 3, 2025, indicated the following: - August 26, 2025, R2 admitted to the facility and R2 expressed "unwillingness to cooperate with medication administration". R2 refused all scheduled medications. The above note indicated the licensee attempted to administer medications on August 26, 2025, on the date of admission. R2's initial assessment dated August 26, 2025, included a section titled Review of Medications. The section did not list any medication. The	01700		

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01700	Continued From page 66 section titled Ability to Self-Manage Medications indicated the R2 took no medications. R2's Medication Assessment for Safety in Self Administration assessment dated August 26, 2025, indicated R2 was deemed unable to safely self-administer medications and R2 wanted medications to be managed by the licensee. R2's Individual Medication Management Plan Sample Form dated August 26, 2025, indicated medication would be administered by a staff member, intramuscular injection medication would be taken at the clinic once per month, medications were stored in a medication room, medications were taken whole, nurse was responsible for monitoring supplies and refills, ULP were able to administer oral, topical, and intramuscular injections, and ULP to contact licensed nurse with any questions related to medication administration. In addition, R2 had a history of noncompliance with medication administration. R2's progress notes dated August 26, 2025, through September 3, 2025, did not include a medication assessment. In addition, the notes did not indicate further assessment attempts occurred. On September 10, 2025, at 10:13 a.m., clinical nurse supervisor (CNS)-C stated they attempted to complete an assessment however, R2 had aggressive behaviors and was refusing to complete an assessment with them. CNS-C stated the items completed on the initial assessment were based on what they observed while attempting to conduct the initial assessment.	01700		

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01700	Continued From page 67 On September 10, 2025, at 2:10 p.m., the surveyor inquired if medication management was a service provided to R2 upon admission. CNS-C stated yes, and they believed they printed out the wrong documentation for R2. CNS-C stated R2 was just noncompliant with taking medication however, the licensee was supposed to administer the medications. CNS-C stated their normal procedure was to set up a primary care visit and receive medication information from the prescriber. CNS-C stated R2's medication assessment was "different" as R2 refused to see a doctor. The licensee's Medication Management Policy dated August 1, 2021, indicated medication management would be carried out in compliance with Minnesota Statutes chapter 144G, Minnesota Department of Health (MDH) rules, and the Minnesota Nurse Practice Act. Registered nurses (RN) would assess residents for medication needs, delegated tasks, monitor competency, and review MARs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01720 SS=F	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record.	01720		

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	37197	A. BUILDING: _____ B. WING _____	09/10/2025

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01720	Continued From page 68 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted the licensee on July 5, 2025, and began receiving assisted living services. R1's diagnoses included anxiety and depression. R1's service plan signed August 6, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". R1's Individualized Medication Management Plan Sample form dated July 10, 2025, indicated R1's medications were administered by staff. R1's Medication Administration Record (MAR) dated August 1, 2025, through August 30, 2025, indicated R1 received amitriptyline 25 milligrams	01720		

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01720	Continued From page 69 (mg) daily, aripiprazole 20 mg daily, olanzapine 20 mg daily, omeprazole 20 mg daily, and prazosin 1 mg daily. The following medication were circled indicating medication was not administered and lacked documentation as to why they were not administered: - amitriptyline 25 mg not administered 9 times; - aripiprazole 20 mg not administered 5 times; - olanzapine 20 mg not documented on for 6 days, and not administered 10 times; - omeprazole not administered 4 times; and - prazosin 1 mg not documented on for 1 day and not administered 11 times. The MAR lacked any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed. R1's progress notes dated July 10, 2025, through August 28, 2025, indicated the following: - July 13, 2025, ULP reported R1 was refusing medications to clinical nurse supervisor (CNS)-C however, R1 was unavailable during CNS-C visit; - July 14, 2025, CNS-C educated R1 on taking their medications regularly; - July 22, 2025, ULP reported R1 refusing medications. No information was documented if there was a discussion related to medication refusals; and - July 30, 2025, CNS-C educated R1 on importance of taking prescribed medications. R1 agreed to take medications going forward. ULP were to continue to monitor of noncompliance of medication administration. Although there was documentation related to discussions of medication refusal possible consequences in July, the licensee failed to continue to have conversations and document the conversations in the medication record in the	01720		

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01720	Continued From page 70 month of August. R2 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's MAR dated September 1, 2025, through September 30, 2025, included the following medications: benztropine mesylate 1 milligram (mg) twice per day, cetirizine hydrochloride 10 mg daily, ciclopirox solution apply to affected area daily, famotidine 20 mg daily, fluphenazine decanoate 25 mg injected intramuscularly every three weeks, omeprazole 20 mg daily, Systane 0.6 percent (%) solution one drop in both ears twice a day, vitamin D3 25 micrograms (mcg) daily. The following medication were circled indicating medication was not administered and lacked documentation as to why they were not	01720		

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01720	Continued From page 71 administered: - benztropine not administered 12 times; - cetirizine HCL not administered 6 times; - famotidine not administered 8 times; and - omeprazole not administered 5 times. In addition, the MAR did not have any documentation under Systane, vitamin D3, and ciclopirox, all scheduled medications, on September 7, 2025, and September 9, 2025. The MAR lacked any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed. R2's progress notes dated August 26, 2025, through September 3, 2025, indicated the following: - August 26, 2025, R2 admitted to the facility and R2 expressed "unwillingness to cooperate with medication administration". R2 refused all scheduled medications. "Client noncompliance with essential care components (medications, vitals [sic] signs). Safety of client and staff requires ongoing assessment." No documentation was noted on education related to medication administration compliance. - September 3, 2025, refused medication administration after education on importance of each medication. R2 indicated they didn't need the medication and asked staff to stop asking. R2 was reapproached with medication 30 minutes later however continued to refuse the medications. Although R2 was educated on the importance of medication administration one time, the licensee failed to document continued conversations with R2 related to possible consequences of refusals of medication.	01720		

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01720	Continued From page 72 On September 9, 2025, at 11:36 a.m., CNS-C stated staff have had conversations with residents and those conversations would be documented in the progress notes. CNS-C acknowledged the lack of conversations with residents documented in their progress notes related to potential consequences of the resident not taking their medications. The licensee's 2.37 Medication Administration Policy dated August 1, 2021, indicated all medication administration would comply with state and federal regulations including Minnesota Statues chapter 144G, the Minnesota Nurse Practice Act, and applicable Minnesota Department of Health (MDH) rules. Refusals must be documented with a written explanation and reported to the registered nurse (RN) or assisted living director. In addition, medications refusals must be documented on an incident report within 24 hours, prescriber and responsible party would be notified, and corrective action would be taken to prevent reoccurrence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 73 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the reason why medication administration was not completed as prescribed for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted the licensee on July 5, 2025, and began receiving assisted living services. R1's diagnoses included anxiety and depression. R1's service plan signed August 6, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". R1's Individualized Medication Management Plan	01760		

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01760	Continued From page 74 Sample form dated July 10, 2025, indicated R1's medications were administered by staff. R1's Medication Administration Record (MAR) dated August 1, 2025, through August 30, 2025, indicated R1 received amitriptyline 25 milligrams (mg) daily, aripiprazole 20 mg daily, olanzapine 20 mg daily, omeprazole 20 mg daily, and prazosin 1 mg daily. The following medication were circled indicating medication was not administered: - amitriptyline 25 mg not administered 9 times; - aripiprazole 20 mg not administered 5 times; - olanzapine 20 mg not documented on for 6 days, and not administered 10 times; - omeprazole not administered 4 times; and - prazosin 1 mg not documented on for 1 day and not administered 11 times. The MAR lacked the reason why medication administration was not completed as prescribed and lacked documentation of any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed. In addition, the MAR contained initials of staff, however lacked signature and title of the person who administered the medication. R2 R2 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans.	01760		

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01760	Continued From page 75 R2's unsigned and undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. R2's MAR dated September 1, 2025, through September 30, 2025, included the following medications: benztropine mesylate 1 milligram (mg) twice per day, cetirizine hydrochloride 10 mg daily, ciclopirox solution apply to affected area daily, famotidine 20 mg daily, fluphenazine decanoate 25 mg injected intramuscularly every three weeks, omeprazole 20 mg daily, Systane 0.6 percent (%) solution one drop in both ears twice a day, vitamin D3 25 micrograms (mcg) daily. The following medication were circled indicating medication was not administered: - benztropine not administered 12 times; - cetirizine HCL not administered 6 times; - famotidine not administered 8 times; and - omeprazole not administered 5 times. In addition, the MAR did not have any documentation under Systane, vitamin D3, and ciclopirox, and all scheduled medications were not documented on September 7, 2025, and September 9, 2025. The MAR lacked the reason why medication administration was not completed as prescribed and lacked documentation of any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 76 administered as prescribed. In addition, the MAR contained initials of staff, however lacked signature and title of the person who administered the medication. On September 9, 2025, at 11:36 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained if a resident refused a medication the ULP was supposed to circle the medication and write the reason of refusal on the back of the MAR. CNS-C stated, "No one did it." The surveyor inquired if they could tell which initial corresponded with what employee. CNS-C stated the initial would correspond with the name on the licensee's staff schedule. CNS-C stated they were unable to tell who administered each medication from the MAR. The licensee's 2.37 Medication Administration Policy dated August 1, 2021, indicated all medication administration would comply with state and federal regulations including Minnesota Statues chapter 144G, the Minnesota Nurse Practice Act, and applicable Minnesota Department of Health (MDH) rules. Refusals must be documented with a written explanation and reported to the registered nurse (RN) or assisted living director. In addition, medications refusals must be documented on an incident report within 24 hours, prescriber and responsible party would be notified, and corrective action would be taken to prevent reoccurrence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 77	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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 admitted to the licensee on August 26, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's record included two different service plans. R2's unsigned and undated Service Plan	01820		

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01820	Continued From page 78 indicated R2 received assistance with housekeeping, laundry, shopping, money management, appointments, transportation, socialization, meals, medication set up and administration, and behavior management. R2's second Service Plan was signed by a staff member on August 26, 2025, however lacked R2's signature and did not identify any services the licensee would provide to R2. On September 9, 2025, at 9:50 a.m., the surveyor observed housing manager (HM)-A and clinical nurse supervisor (CNS)-C enter the medication closet to attempt to provide R2 medication R2 was requesting. R2's Medication Administration Record (MAR) dated September 1, 2025, through September 30, 2025, included the following medications: benztropine mesylate 1 milligram (mg) twice per day, cetirizine hydrochloride 10 mg daily, ciclopirox solution apply to affected area daily, famotidine 20 mg daily, fluphenazine decanoate 25 mg injected intramuscularly every three weeks, omeprazole 20 mg daily, Systane 0.6 percent (%) solution one drop in both ears twice a day, vitamin D3 25 micrograms (mcg) daily, clonidine hydrochloride (HCL) 0.1 mg as needed (PRN) twice per day, hydroxyzine HCL 50 mg PRN three times per day, and ibuprofen 600 mg as needed. R2's record lacked signed prescriber orders for any of the medication listed above. R2's Current Medications at Discharge form dated August 27, 2025, indicated at R2's previous facility they received benztropine	01820		

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01820	Continued From page 79 mesylate 1 mg daily, cetirizine HCL 10 mg daily, ciclopirox 8 % topically to affect area daily, famotidine 20 mg daily, fluphenazine deconate 25 mg injected every 3 weeks, omeprazole 20 mg daily, Systane 0.6 % in both ears daily for dry eyes, vitamin D3 25 mcg daily, clonidine HCL 0.1 daily PRN, hydroxyzine HCL 50 daily PRN, and ibuprofen 600 mg daily PRN. The list was signed by a registered nurse (RN) and licensed assisted living director (LALD)-D. The document did not contain a prescriber's signature. On September 9, 2025, at 9:56 a.m., CNS-C they did not have prescriber orders for R2, and they based R2's MAR off of the document titled Current Medications at Discharge. CNS-C the medication the licensee had on hand was provided by R2's previous facility. CNS-C stated they had tried to get information from R2 to set up a medical appointment however, R2 would not provide them with information and due to HIPPA they would be unable to set up a medical appointment for the R2 without the information. The surveyor inquired if they attempted to contact the prescriber written on the document Current Medications at Discharge. CNS-C stated they had not contacted any provider. The surveyor inquired if they were able contact R2's guardian for the information they needed to make an appointment. CNS-C stated they did contact the guardian however; they were unable to provide them with the information they needed. On September 9, 2025, at 10:45 a.m., the surveyor contacted the provider listed on the document titled Current Medications at Discharge. Triage registered nurse (RN)-G stated the medications listed on the medication administration record were correct except the	01820		

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01820	Continued From page 80 following: - Systane 0.6 % was discontinued; and - fluphenazien deaconate 25 mg injection was discontinued in May 2025. On September 10, 2025, at 2:10 p.m., the surveyor inquired why the licensee began medication administration on R2 if the licensee did not have a prescriber order. CNS-C stated medications came with R2 from the previous facility and "I am not going to leave him not taking any of the meds." The licensee's Medication Management Policy Dated August 1, 2021, indicated medications would only be given with a valid written order from a licensed prescriber. The order must include the resident name, medication name, dose, route, frequency, and prescriber's signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

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01910	Continued From page 81 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of medications being managed by the licensee when the resident's medication management services ended for three of three residents (R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at approximately 10:45 a.m., during a facility tour, the surveyor observed the following in the licensee's medication closets: - R5 30 bubble filled packets which contained one rosuvastatin 40 milligram (mg) tablet, and valsartan 160 mg tablet in each packet. one bottle of acetaminophen extra strength 500 mg,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01910	Continued From page 82 and one bottle of ibuprofen 400 mg. - R6 two bottles of diclofenac sodium one percent (%), ten boxes of nicotine transdermal system 21 mg one box of nicotine gum 2 mg; and - R7 one box of nicotine transdermal system 21 mg. R5 R5 discharged from the facility on August 19, 2025. R5's Discharged Summary completed August 19, 2025, indicated the licensee provided assistance with medication management. In addition, R2's medications at discharge included valsartan, rosuvastatin, and lurasidone. The form had a section to document medication disposition. The section read, "NA". R6 R6 died at the licensee's facility on December 13, 2022. R6's Discharge Note dated December 13, 2022, read, "Disposition: Resident has been formally discharged from the facility due to death. Case closed effective December 13, 2022. The note lacked a medication disposition. R7 R7 discharged from the licensee on January 17, 2023, to an independent apartment. R7's Discharge Note dated January 17, 2023, read, "Disposition: Resident has been discharged from the facility effective January 17, 2023. Case closed." The note lacked a medication disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01910	Continued From page 83 R5, R6, and R7's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. On September 8, 2025, at 10:45 a.m., the surveyor inquired why the medications listed above were not disposed of timely. Clinical nurse supervisor (CNS)-C stated they were unaware of why the medications were not disposed of as they were not employed with the licensee at the time of the discharges. CNS-C stated since they had started employment two different residents had discharged, and they did dispose their medications. CNS-C stated they did not dispose R5's medications because R5 was incarcerated and they did not know if they would return to the facility. The licensee's Medication Management Policy dated August 1, 2021, indicated all medication management would be carried out in compliance with Minnesota Statues chapter 144G, Minnesota Department of Health (MDH) rules, and the Minnesota Nurse Practice Act. In addition, Medications that were discontinued or expired would be disposed of according to state and federal law. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

UNIQUE HOMES LLC
3940 46TH AVENUE NORTH
Robbinsdale, MN 55422
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37197

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

Inspection Info

Report Number: F1013251079
Inspection Type: Full - Single
Date: 9/8/2025 Time: 12:40 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: 9/8/25 REPEAT
THE KITCHEN DISH MACHINE SANITIZES WARE WITH HOT WATER. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE. DISCUSSED TEST KITS WITH STAFF. ORDER WAS ISSUED ON 7/12/22.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: GREASE BUILDUP WAS LOCATED ON THE BOTTOM OF THE MICROWAVE ABOVE THE STOVE. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: 9/8/25 REPEAT
PER STAFF WARE IS WASHED WITH WATER AND SOAP. NUMEROUS WARE (POTS, PANS, UTENSILS) WERE ON A RACK AIR DRYING NEAR THE SINK. THE DISH MACHINE WAS NOT IN USE. COMPLY WITH RULE. DISCUSSED WARE WASHING AND SANITIZING PROCEDURES. STAFF MUST SANITIZE WARE USING THE DISH MACHINE. ORDER WAS ISSUED ON 7/12/22.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator A. Crews.

The establishment has a residential kitchen and serves food prepared that day. The kitchen has wood cabinets, wood plank floor, tile walls, laminate counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is available to wash ware. The dish machine should be run on the high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

A freezer was located in the garage.

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 F1013251079 from 9/8/2025

Jerry Malloy

John Weah Merchant
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

UNIQUE HOMES LLC
Robbinsdale
County/Group: Hennepin County

Inspection Info

Report Number: F1013251079
Inspection Type: Full
Date: 9/8/2025
Time: 12:40 PM

Food Temperature: Product/Item/Unit: Pizza**; Temperature Process:** Cold-Holding
Location: Freezer - garage at 25 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 38 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

UNIQUE HOMES LLC
Robbinsdale
County/Group: Hennepin County

Inspection Info

Report Number: F1013251079
Inspection Type: Full
Date: 9/8/2025
Time: 12:40 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No