Electronically Delivered

October 9, 2025

Licensee
Elderwood of Hinckley
710 Spring Lane
Hinckley, MN 55037

RE: Project Number(s) SL23986016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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: SL23986016-0 On August 25, 2025, through August 27, 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 36 residents; 36 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on August 26 , 2025, issued for tag identification 1290 at a scope and level of widespread, level three (l). The licensee took mitigating actions, however, the correction order remains at a scope and level of l.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. In addition, the licensee failed to ensure	0 470		

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0 470	Continued From page 2 the daily staffing schedule was posted in a central location as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 36 residents, with a current census of 36 residents. During the facility tour on August 25, 2025, with licensed practical nurse (LPN)-C at 1:00 p.m., the surveyor did not observe the daily staffing schedule posted. During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated O/CNS-B had developed the staffing plan. O/CNS-B further stated the licensee's regular staffing schedule was the following: -three unlicensed personnel (ULP) worked 6:00 a.m. until 2:00 p.m.; -three ULPs worked 2:00 p.m. until 10:00 p.m.; and -two ULPs worked 10:00 p.m. until 6:00 a.m. The (licensee name) Staffing Plan dated June 24,	0 470		

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0 470	Continued From page 3 2023, indicated the following: -two floor ULPs and one med (medication) passer 6:00 a.m. until 2:00 p.m.; -two floor ULPs and one med (medication) passer 2:00 p.m. until 10:00 p.m.; -one floor ULP and one med (medication) passer for NOC (night shift) no times indicated; -two staff for kitchen /cook no times indicated; -two office support 8:00 a.m. until 4:00 p.m.; -one licensed practical nurse (LPN) 8:00 a.m. until 4:00 p.m.; -one RN (registered nurse) in building eight hours per day and on call 24 hours/day-seven days per week; -one maintenance staff 8:00 a.m. until 3:30 p.m.; -one staff kitchen 4:00 p.m. until 8:00 p.m.; -one housekeeper 7:00 a.m. until 3:00 p.m.; -owners onsite five days per week- eight hours per day-different hours during the day- owners are on call 24 hours per day and seven days per week [sic]; and -evaluation of this staffing plan, for appropriateness of the level of staff, to meet the needs of residents at (licensee name) will be conducted by administrator and/or RN, at least twice per year [sic]. The undated (licensee name) Staffing Plan indicated the following: -three female office/administration employees; -one female assistant employee; -two male and thirty female HHA (home health aide)/CNA (certified nursing assistant) (ULP) employees; -one female LPN employee; -two female RN employees; -two female housekeeping employees; -two male and one female kitchen cook employees;	0 470		

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0 470	Continued From page 4 -two male and three female kitchen aid employees; -one male maintenance employee; and -one male and one female owner employees. The licensee's staffing plan lacked evidence a metric was used to determine staffing needs and being reviewed at least twice per year. In addition, the licensee lacked evidence a daily staffing schedule was posted. On August 27, 2025, at 9:21 a.m., O/CNS-B stated the licensee had a daily staffing schedule posted in the ULP office, however, O/CNS-B stated residents and visitors were not generally allowed to enter the ULP office. O/CNS-B stated O/CNS-B was not aware a daily staffing schedule had to be posted in a central area. O/CNS-B stated O/CNS-B developed the staffing schedule based on the number of residents and their care levels. O/CNS-B further stated usually two to four ULPs were scheduled per shift and O/CNS-B had estimated in O/CNS-B's head the amount of ULPs needed to meet the needs of all residents and had not documented the information. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3, effective October 2022, the CNS must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: (A) each resident's needs, as identified in the resident's service plan and assisted living contract; (B) each resident's acuity level, as determined by	0 470		

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0 470	Continued From page 5 the most recent assessment or individualized review; (C) the ability of staff to timely met the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; (D) whether the facility has a secured dementia care unit; and (E) staff experience, training, and competency. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 6 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 550		

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0 550	Continued From page 7 During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee was familiar with current minimum assisted living requirements. During the facility tour on August 25, 2025, with licensed practical nurse (LPN)-C at 1:00 p.m., the surveyor did not observe the OOMHDD contact information posted. On August 27, 2025, at 9:29 a.m., the surveyor reviewed the licensee's postings with O/CNS-B. O/CNS-B stated O/CNS-B had thought the OOMHDD contact information was posted, however, O/CNS-B was unable to locate the OOMHDD contact information with the licensee's postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the	0 580		

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0 580	Continued From page 8 time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee did not have a quality management plan, however, has had meetings and discussed resident concerns. On August 26, 2025, at 12:15 p.m., O/CNS-B stated for quality management the licensee discussed "things" on certain dates, however, the licensee did not document any of the meetings. O/CNS-B further stated the licensee did not have a specific topic to discuss for quality management at this time. No further information was provided.	0 580		

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0 580	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), which included completion of a facility TB risk assessment. In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of a TB screening such as a blood test for one of two employees (licensed practical nurse (LPN)-C).	0 660		

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0 660	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee was familiar with current minimum assisted living requirements. TB RISK ASSESSMENT On August 27, 2025, at 9:37 a.m., the surveyor reviewed the undated Appendix B. TB risk assessment worksheet provided by O/CNS-B. The worksheet indicated the facility was at low risk due to no TB patients (residents) encountered at the setting (facility) and was initially completed in 2015. The worksheet did not indicate when the last TB risk assessment was conducted nor how frequently the TB risk assessment was conducted. O/CNS-B stated O/CNS-B had completed the Appendix B. TB risk assessment worksheet sometime in the last year, however, O/CNS-B stated the worksheet lacked a date of completion. O/CNS-B further stated O/CNS-B was not aware of the Facility TB Risk Assessment for Health Care Settings Licensed by MDH. for Health Care Settings Licensed by MDH, however, had used the Appendix B TB risk assessment worksheet issued September 27, 2006.	0 660		

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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
0 660	Continued From page 11 The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated settings should perform a facility risk assessment on an annual basis. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website last updated July 1, 2025, indicated each provider licensed by MDH is required to complete a TB risk assessment annually. TB SCREENING LPN-C was hired on February 8, 2025, to provide direct care services and supervision to staff and residents at the assisted living with dementia care facility. Throughout the survey on August 25, 2025, through August 27, 2025, the surveyor observed LPN-C interacting with staff and residents at the facility. LPN-C's employee record contained a negative TB screen and first step TST dated February 8, 2025. LPN-C's employee record included a second step TST administered on February 26, 2025, at 1609 (4:09 p.m.), and was read on February 28, 2025, at 1301 (1:01 p.m.) (48 hours had not passed after the TST was administered). On August 27, 2025, at 9:36 a.m., O/CNS-B stated LPN-C's second TST should have been read after 48 hours, however, O/CNS-B might have just written in the wrong time LPN-C's second TST was read.	0 660		

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	23986	A. BUILDING: _____ B. WING _____	08/27/2025

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0 660	Continued From page 12 The licensee's undated Employee Screening for TB indicated employees must return in 48-72 hours to have a test (TST) read or it (TST) will be re-administered at the cost of the employee. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff 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	0 680		

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0 680	Continued From page 13 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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to post EPP prominently. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee was familiar with current minimum assisted living requirements.	0 680		

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0 680	Continued From page 14 During the facility tour on August 25, 2025, with licensed practical nurse (LPN)-C at 1:00 p.m., the surveyor did not observe the EPP location posted. The licensee's EPP, dated June 1, 2022, provided to the surveyor included generic instructions for staff to follow in the case of a fire, severe weather, and removing residents from the facility. The licensee's EPP provided did not include the following: - annual review of the EPP; - a missing resident policy and quarterly review of the missing resident policy; - policies and procedures to address natural disasters, man-made disasters, facility-based disasters, and infectious disease; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and	0 680		

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0 680	Continued From page 15 availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; - a method of sharing information from the EPP with residents and their families; and - an EP training and testing program. On August 27, 2025, at 9:42 a.m., O/CNS-B stated O/CNS-B was not familiar with the requirements of the EPP nor Appendix Z. O/CNS-B further stated the licensee's EPP was located in the unlicensed personnel (ULP) office and the location of the EPP was not posted. O/CNS-B stated the licensee completed fire drills to test the EPP, however, the licensee did not	0 680		

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0 680	Continued From page 16 conduct other EPP tests or tabletop exercises. The licensee Disaster Planning and EPP and Procedure policy dated June 1, 2022, indicated to ensure safety of residents and staff. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	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:	0 775		

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0 775	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code (MSFC) Rules, Chapter 7511. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 27, 2025, at 10:05 a.m., the surveyor toured the facility with owner/clinical nurse supervisor (O/CNS)-B and housekeeping (H)-M. During the facility tour, the surveyor observed the following: Egress Door Locking Electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. - Two doors were installed at the main front exit, a controlled egress locking system was installed on the first door (interior), the second door leading to the exterior had a thumb turn deadbolt lock installed. - Push button locks were installed on the door handles of the emergency exit doors located on the sides and back of the building. During the facility tour interview, O/CNS-B verified the above listed locking observations and	0 775		

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0 775	Continued From page 18 stated these locks were not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position. All egress paths must be maintained free of obstruction that would cause a delay in exiting of the space during a fire or similar emergency. Emergency Light Maintenance Emergency lights did not work when tested by O/CNS-B and H-M in the following locations: - at the main entrance - at the exit door leading to the back of the building - at the side exit door leading to the exterior enclosed patio Additionally, the emergency light test was dim in the living room. During the facility tour interview, O/CNS-B and H-M verified the above listed emergency light observations. Emergency lights must be maintained to ensure sufficient illumination will be provided to allow the building occupants to safely evacuate in the event of an emergency. Smoke Detectors Smoke detectors had been relocated from the original installation locations in mechanical and storage rooms, and in the exit path leading to the exterior enclosed patio. Holes and/or empty brackets remained in the ceiling where the detectors had been previously installed. During the facility tour interview, O/CNS-A verified the smoke detector observations and stated they would call maintenance. O/CNS-B stated the smoke detectors had been moved because of cold air. Smoke detectors must be installed and maintained per manufacturer's specifications.	0 775		

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0 775	Continued From page 19 Space Heaters Space heaters were plugged into wall outlets in occupied resident rooms 1, 4, and 24, creating fire hazards. During the facility tour interview, O/CNS-B and H-M verified the space heater observations. Egress Through Intervening Spaces Curtains were used to divide rooms 14, 15, 17, and 18 into double occupancy rooms, by creating two separate sleeping areas. The emergency exit path from the back sleeping area required passing through the front sleeping area to access the door leading into the corridor. During the facility tour interview, O/CNS-B and H-M verified the above listed double occupancy room observations. Sleeping area means of egress shall not lead through other sleeping areas. Obstructed Egress - Exit paths adjacent to rooms 14 and 11 were used for storage. - In the sitting room, furniture was located in front of the exit door leading to the back of the building. During the facility tour interview, O/CNS-B and H-M verified these egress path observations. Paths for egress escape are required to be maintained clear of obstructions. Fire Door Maintenance - The gasketing was missing from the fire door frame for occupied resident room 18. - In resident rooms 5, 10, and 12, when labeled fire doors were closed, these doors failed to positively latch. During the facility tour interview, O/CNS-B and H-M verified the fire door assembly observations. Fire door assemblies must be maintained as	0 775		

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0 775	Continued From page 20 designed. Carbon Monoxide Alarms Carbon monoxide alarms were not installed within ten feet of all sleeping rooms. During the facility tour interview, O/CNS-B verified carbon monoxide alarms were not installed in these areas. Fire Sprinkler System Maintenance - The inspection tag attached to the fire sprinkler system was dated 2023. - Fire sprinklers were obstructed in the resident kitchen, commercial kitchen warewash area, and in a storage room adjacent to the sitting room. - The escutcheon was missing from a fire sprinkler in the storage room adjacent to the sitting room. During the facility tour interview, O/CNS-B and H-M verified the sprinkler system observations. Fire sprinkler systems shall be maintained in accordance with MSFC in Minnesota Rules Chapter 7511. Electrical - Electrical panels were obstructed by storage in the mechanical room closet for the laundry room. - Extension cords were used to supply power for the exterior patios. - Multiplug adapters were used to supply power in resident rooms 1, 15, 17, and for a power supply shelter on the exterior side patio. During the facility tour interview, O/CNS-A and H-M verified the above listed electrical observations. Electrical panels must be maintained as readily accessible. Improper use of extension cords and multiplug adapters creates a fire hazard.	0 775		

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0 775	Continued From page 21 Fire Resistant Wall Maintenance - There was a hole in the wall of the mechanical room identified as 144 on the posted floor plan. - There were holes in the laundry room wall where unused metal ducting was installed. During the facility tour interview, O/CNS-A and H-M verified the above listed wall observations. Fire resistant walls shall be maintained free of holes. Smoking Material Disposal Burnt cigarettes and paper cups were disposed of in an uncovered metal bucket stored on a wood table on exterior patio at the side of the building. During the facility tour interview, H-M verified the above listed smoking material disposal observations. Improper disposal of smoking materials creates a fire hazard. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not	0 780		

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0 780	Continued From page 22 including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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: On August 27, 2025, at 10:05 a.m., the surveyor toured the facility with owner/clinical nurse supervisor (O/CNS)-B and housekeeping (H)-M.	0 780		

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0 780	Continued From page 23 During the facility tour, the surveyor observed curtains were used to divide rooms 14, 15, 17, and 18 into double occupancy rooms, by creating two separate sleeping areas. Smoke alarms were installed in the front sleeping areas. Smoke alarms were not installed in the back sleeping areas located behind the curtains. During the facility tour interview, O/CNS-B and H-M verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 24 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 maintain the fire safety and evacuation plan with required content, make all parts of the plan readily available, and provide required training and drills. 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 August 27, 2025, owner/clinical nurse supervisor (O/CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 25 FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to accurately identify resident sleeping rooms evident by the following: On August 27, 2025, at 10:05 a.m., the surveyor toured the facility with O/CNS-B and housekeeping (H)-M. During the facility tour, the surveyor observed the following: Numbers were posted at resident sleeping room doors (1-24). One of the undated posted emergency evacuation floor plans, labeled resident sleeping rooms as 108-120 and 131-143. Additionally, this floor plan did not label the emergency exits. The number identifiers installed on or at the resident sleeping room doors must correspond with all posted floor plans to provide efficient communication for exiting in the event of a fire or similar emergency. Exit labels are required to be included on all posted floor plans in order to direct occupants to the designated exits in the event of an emergency. The resident rooms used as double occupancy were not identified on any of the emergency evacuation floor plans or in the written employee procedures. Record review of the available documentation indicated the licensee failed to maintain the FSEP with site specific procedures. The FSEP inaccurately referenced fire doors on magnetic holders that will automatically close. The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan.	0 810		

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0 810	Continued From page 26 During an interview on August 27, 2025, at 2:00 p.m., O/CNS-B stated residents requiring staff assistance in an emergency had been identified in their care plans and these procedures were maintained electronically on the computer. These individualized evacuation procedures were not included with the printed copy of the FSEP. All parts of the FSEP must be maintained as readily available for accessibility. During an interview on August 27, 2025, at 2:00 p.m., O/CNS-B verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by training documentation lacking the required frequency. Resident training records were provided, dated 2022. No additional training documentation was provided. During an interview on August 27, 2025, at 2:00 p.m., O/CNS-B verified the resident training frequency was not met. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by training documentation lacking the required frequency. Records for employee FSEP training at the time of hire were provided. During an interview on August 27, 2025, at 2:00 p.m., O/CNS-B stated employees were trained at the time of hire and verified site specific FSEP training was not completed at least twice per year. O/CNS-A stated employees completed an annual online fire safety and evacuation training from a third	0 810		

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0 810	Continued From page 27 party provider. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill documentation lacking the required frequency. Fire drill and evacuation reports were provided. Drills were recorded in September and November 2024. Drills were recorded in January, April, June, and August 2025. The simulated conditions were the same for all of these drills. During an interview on August 27, 2025, at 2:00 p.m., O/CNS-B verified the evacuation fire drill frequency was not met. The frequency and simulated conditions of a fire drill shall assess the effectiveness of the emergency procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain	0 950		

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0 950	Continued From page 28 information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three residents' (R1, R2, R3) assisted living contracts included a notice with the required verbiage for the residents to identify a designated representative. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on December 14, 2018, and	0 950		

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0 950	Continued From page 29 began receiving assisted living services on August 1, 2021. R1's Residency Agreement, identified as the contract, was signed by R1 on July 20, 2022. R2 R2 was admitted on December 7, 2012, and began receiving assisted living services. R2's Residency Agreement, identified as the contract, was signed by R2 on December 7, 2022. R3 R3 was admitted on July 11, 2023, and began receiving assisted living services. R3's Residency Agreement, identified as the contract, was signed by R3 on July 20, 2022. R1, R2, and R3's contract lacked the following required verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On August 27, 2025, during an interview with	0 950		

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0 950	Continued From page 30 owner/clinical nurse supervisor (O/CNS)-B from 1:20 p.m. to 1:45 p.m., O/CNS-B stated the same contract template was utilized for all residents and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 31 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (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).	01060		

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01060	Continued From page 32 The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R7's diagnoses included traumatic brain injury, hypertension (HTN-high blood pressure), and chronic obstructive pulmonary disease (COPD-difficult breathing). R7's undated Treatment Plan (service plan) indicated R7's services included medication administration, bathing, grooming, dressing, behavior management, and housekeeping. R7's Nurses Report dated August 7, 2025, indicated R7 was sent to the hospital on August 6, 2025. R7's Nurses Progress Notes included the following entries: -August 12, 2025, at an unknown time, R7 returned from the hospital, however, unable to stop bleeding, so R7 was sent to the ER (emergency room) to be seen. -August 20, 2025, R7 returned to the facility from the hospital. R7's Treatment Administration Record dated August 2025, indicated R7 was on LOA (leave of absence) due to hospitalization August 6, 2025, through August 20, 2025. R7's record lacked a written notice that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 33 - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R7's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On August 26, 2025, at 2:30 p.m., O/CNS-B stated staff entered a nurse note if a resident gets admitted to the hospital and the licensee does not provide a written emergency relocation notice. Licensed practical Nurse (LPN)-C stated the licensee had contacted the resident's county case manager for notification of a hospitalization, however, the licensee was not aware of the emergency relocation requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 34 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a cleared Department of Human Services (DHS) background study prior to providing services, for eight of fifty-one employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F, ULP-G, ULP-H, ULP-I, maintenance (M)-J, cook (C)-K). This had the potential to affect all residents living in the facility. This resulted in an immediate correction order on August 26, 2025. 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:	01290		

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01290	Continued From page 35 During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee was aware of required contents in an employee record. ULP-D ULP-D was hired on October 30, 2015, and began to provide direct care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated ULP-D last worked unsupervised on August 25, 2025, from 6:00 a.m. to 2:00 p.m., and was scheduled to work on August 26, 2025. ULP-E ULP-E was hired on May 5, 2020, and began to provide direct care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24, 2025, through September 6, 2025, indicated ULP-E last worked unsupervised on August 21, 2025, from 7:00 a.m. to 2:00 p.m., and was scheduled to work on September 2, 2025. ULP-F ULP-F was hired on September 23, 2010, and began to provide direct care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated ULP-F last worked unsupervised on August 25, 2025, from 7:00 a.m. to 3:00 p.m., and was scheduled to work on August 26, 2025.	01290		

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01290	Continued From page 36 ULP-G ULP-G was hired on August 2, 2021, to provide direct care services to the assisted living residents. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated ULP-G last worked unsupervised on August 25, 2025, from 2:00 p.m. to 10:00 p.m., and was scheduled to work on August 27, 2025. ULP-H ULP-H was hired on December 30, 2021, and began to provide direct care services to the assisted living residents. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated ULP-H last worked unsupervised on August 25, 2025, from 8:00 a.m. to 2:00 p.m., and was scheduled to work on August 26, 2025. ULP-I ULP-I was hired on October 20, 2020, and began to provide direct care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated ULP-I last worked unsupervised on August 25, 2025, from 6:00 a.m. to 2:00 p.m., and was scheduled to work on August 29, 2025. M-J M-J was hired on January 4, 2016, and began to provide indirect care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24,	01290		

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01290	Continued From page 37 2025, through August 30, 2025, indicated M-J last worked unsupervised on August 25, 2025, from 8:30 a.m. to 3:30 p.m., and was scheduled to work on August 26, 2025. C-K C-K was hired on March 2, 2016, and began to provide indirect care services to the assisted living residents on August 1, 2021. The weekly staff schedule dated August 24, 2025, through August 30, 2025, indicated C-K last worked unsupervised on August 25, 2025, from 7:00 a.m. to 2:00 p.m., and was scheduled to work on August 26, 2025. The licensee's NETStudy 2.0 employee background study roster printed August 25, 2025, lacked a background study clearance for ULP-D, ULP-E, ULP-F, ULP-G, ULP-H, ULP-I, M-J, and C-K. On August 25, 2025, at 3:55 p.m., O/CNS-B stated the licensee had background clearance letters for Health Identification number (HFID) 27972. O/CNS-B stated further she had spoken with the owner/licensed assisted living director (LALD)-A and O/LALD-A had assumed NETStudy was transferring staff to the new assisted living HFID 23986, however, O/CNS-B stated the above staff were not listed on the NETStudy for HFID 23986. The licensee's Background Study policy dated May 31, 2022, indicated designated staff for facility will upon hire gather all the necessary information to conduct background study with finger printing. The commissioner of health shall contract with the commissioner of human	01290		

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01290	Continued From page 38 services to conduct background studies of: individuals specified in section 245C.01, subdivision 1, who perform direct contact services and all other employees in assisted living in an assisted living facility or assisted living facility with dementia licensed under sections 144.50 to 144.58. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01420	Continued From page 39	01420		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, instructions in the resident record for delegated tasks provided by unlicensed personnel (ULP) for one of three residents (R1) who received catheter cares, colostomy cares and gastrostomy tube (g-tube) cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a	01420		

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	23986	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01420	Continued From page 40 limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), major depressive disorder, and cerebrovascular disease (conditions that impact the brain's blood vessels and blood flow). R1's Service Plan dated August 19, 2024, indicated R1's services included medication administration, assistance with toileting, bathing, grooming, dressing, catheter care, colostomy care, transferring, bed mobility, laundry, and housekeeping. R1's August 2025 treatment administration record indicated the following: -catheter, switch out catheter bags every evening, clean/rinse out with one-half water, one half vinegar solution, empty each shift and record output; -S/P (suprapubic) site cleaning-Wash with mild soap and water 2 times a day; -g-tube site cleaning, wash with mild soap and water, apply split sponge; and -colostomy instructions-empty when one-third full, open Velcro, empty contents into a graduate container, wipe end of pouch for cleanliness, close Velcro back. Empty contents when one-half full helps to reduce the bag leaking and breaking open. On August 26, 2025, at 12:45 p.m., the surveyor observed ULP-N check contents of R1's colostomy bag. R1's record lacked specific written instructions for	01420		

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01420	Continued From page 41 catheter cares, suprapubic site cares, g-tube site cares, and colostomy cares or when to contact and RN should problems arise. On August 27, 2025, during an interview from 1:20 p.m. to 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated R1's delegated tasks as above did not include specific instructions for ULPs or when to contact a nurse should a problem arise. O/CNS-B stated she was unsure why specific instructions was not included in the resident record. The undated licensee's Resident Record Requirements-Assisted Living Facilities policy indicated each resident record must include required documentation relevant to resident services or status. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues	01540		

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01540	Continued From page 42 arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (owner/clinical nurse supervisor (O/CNS)-B, licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-L) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license effective December 1, 2024, through November 30, 2025.	01540		

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01540	Continued From page 43 During the entrance conference on August 25, 2025, at 1:45 p.m., O/CNS-B stated the licensee was aware of required contents in an employee record. O/CNS-B O/CNS-B was hired in 2012, and provided direct care and registered nurse (RN) on call services and supervision to residents and staff at the assisted living with dementia care facility effective August 1, 2021. Throughout the survey on August 25, 2025, through August 27, 2025, the surveyor observed O/CNS-B interacting with staff and residents at the facility. LPN-C LPN-C was hired on February 8, 2025, to provide direct care services and supervision to staff and residents at the assisted living with dementia care facility. Throughout the survey on August 25, 2025, through August 27, 2025, the surveyor observed LPN-C interacting with staff and residents at the facility. ULP-L ULP-L was hired on May 2, 2025, to provide direct care services to residents at the facility. On August 26, 2025, at 6:55 a.m., the surveyor observed ULP-L administer R10's scheduled morning medications. O/CNS-B, LPN-C, and ULP-L's employee records contained Mental Health and/or Problem Solving Techniques quizzes. The quizzes	01540		

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01540	Continued From page 44 included the employees name and were dated. The employees answered the quizzes with true or false, however, the quizzes were not for true or false answers and instead were asking for a word definition or written out answers to open ended questions. O/CNS-B, LPN-C, and ULP-L's employee records lacked O/CNS-B, LPN-C, and ULP-L had completed training on mental illness or de-escalation by July 1, 2025. On August 27, 2025, at 9:34 a.m., O/CNS-B stated O/CNS-B, LPN-C, and ULP-L had all worked more than 80 hours at the licensee. O/CNS-B further stated O/CNS-B recalled completing a mental illness training before, however, O/CNS-B would need to check to see if it was completed for all employees and O/CNS-B would provide additional documentation. On August 27, 2025, at 10:42 a.m., ULP-H stated ULP-H had received mental illness and de-escalation training in 2024. On August 27, 2025, at 3:58 p.m., the surveyor emailed (electronic mail) O/CNS-B regarding the quizzes received for O/CNS-B, LPN-C, and ULP-L. The surveyor requested how was it determined the training was completed with the knowledge tests (quizzes) provided. In addition, the quizzes lacked who provided the training, the date the training was completed, and how many hours of training was done. The surveyor did not receive any response back via email from O/CNS-B. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October	01540		

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01540	Continued From page 45 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	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	01620		

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01620	Continued From page 46 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident	01620		

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01620	Continued From page 47 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment for one of one resident (R1) following a change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated a comprehensive assessment was to be completed on pre-admission, on admission, 14 days following admission, and then every 90 days, with a change of condition, or following a hospital stay. R1 was admitted on December 14, 2018, and began receiving assisted living services on August 1, 2021.	01620		

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01620	Continued From page 48 R1's diagnoses included hypertension (high blood pressure), major depressive disorder, and cerebrovascular disease (conditions that impact the brain's blood vessels and blood flow). R1's Service Plan dated August 19, 2024, indicated R1's services included medication administration, assistance with toileting, bathing, grooming, dressing, catheter care, colostomy care, transferring, bed mobility, laundry, and housekeeping. On August 26, 2025, at 7:10 a.m., the surveyor observed licensed practical nurse (LPN)-C and unlicensed personnel (ULP)-N transfer R1 with a Hoyer lift (a mechanical device to transfer individuals). R1's progress notes dated April 22, 2025, indicated R1 returned from the hospital with a right tibia fracture from a fall which was treated with a casting (holds bone in place to promote healing), PENA (pneumonia) and acute hypoxic respiratory failure (lack of oxygen in the blood). R1's record indicated a Uniform Assessment Tool Form was completed on March 1, 2025, and June 1, 2025. R1's record lacked an assessment for a change in condition after R1 returned from the hospital on April 22, 2025, with a tibia fracture, pneumonia and respiratory failure. On August 27, 2025, during an interview from 1:20 p.m. to 1:45 p.m., O/CNS-B stated R1's record lacked a change in condition assessment. O/CNS-B stated the assessment must have been overlooked and was not completed.	01620		

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01620	Continued From page 49 The licensee's undated Resident Record Requirements-Assisted Living Facilities policy indicated each resident record must include: -documentation of significant changes in status and actions to be taken. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration 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	01750		

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01750	Continued From page 50 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), major depressive disorder, and cerebrovascular disease (conditions that impact the brain's blood vessels and blood flow). R1's Service Plan dated August 19, 2024, indicated R1's services included medication administration, assistance with toileting, bathing, grooming, dressing, catheter care, colostomy care, transferring, bed mobility, laundry, and housekeeping. On August 26, 2025, at 7:10 a.m., the surveyor observed licensed practical nurse (LPN)-C and unlicensed personnel (ULP)-N transfer R1 with a Hoyer lift (a mechanical device to transfer individuals). R1's August 2025 medication administration record (MAR) indicated the following PRN medications: -acetaminophen 160 milligrams (mg)/5 milliliters per G-tube three times a day PRN; and -oxycodone 10 mg tablet, take one-half tablet by mouth every 4 hours PRN. R1's 90-day assessment dated June 1, 2025, indicated R1 was deemed unable to safely self-administer medications for the following reasons: -physical limitations; and	01750		

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01750	Continued From page 51 -mild cognitive impairment. R1's Individualized Medication Management Plan dated November 10, 2023, did not include specific instruction for PRN pain medications. R1's record lacked specific written instructions for R1's PRN pain medications, including parameters to indicate which pain medication to be administered first. On August 27, 2025, during an interview from 1:20 p.m. to 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated R1's as needed PRN pain medications did not include specific instructions. O/CNS-B stated specific instructions was normally added to the MAR, however, must have been missed. The licensee's 7.03 Medications Management Individualized Plan dated May 31, 2022, indicated [facility] will develop and maintain a current individualized medication management record for each resident based on the resident assessment that must contain the following: -any resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 52 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 25, 2025, at 1:30 p.m., the surveyor and licensed practical nurse (LPN)-C reviewed the south medication cart and observed an opened bottle of R8's chewable vitamin C which had an expiration date of July 2023. LPN-C stated this medication should have been discarded and replaced. The licensee's 7.19 Medications and Supplies-Reordering policy dated May 31, 2022, indicated nursing staff of [facility] will assist resident to make sure medications and supplies are ordered and available as needed.	01890		

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01890	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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
02140	Continued From page 54 The licensee held an assisted living facility with dementia care (ALFDC) license effective December 1, 2024 through November 30, 2025. During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated O/CNS-B was the responsible staff overseeing/providing staff training for dementia care. Throughout the survey on August 25, 2025, through August 27, 2025, the surveyor observed O/CNS-B interacting with staff and residents at the facility. O/CNS-B's employee record lacked an approved skill competency or knowledge test approved by the commissioner. On August 26, 2025, at 12:13 p.m., O/CNS-B stated O/CNS-B had not completed an approved competency or knowledge test approved by the commissioner and O/CNS-B was not aware of the requirement. O/CNS-B further stated O/CNS-B had completed training offered by a provider organization the licensee belonged to, however, O/CNS-B stated O/CNS-B did not receive a certificate from the provider organization. The licensee's undated To Ensure Proper Training and Supervision of Dementia Care policy indicated trainers or supervisors must have at least two years of work experience related to dementia, healthcare, gerontology, or a related filed and completion of equivalent training and successful passing of a competency/knowledge test required by the Commissioner.	02140		

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	23986	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02140	Continued From page 55 The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website last updated July 1, 2025, indicated the following training programs were approved by the commissioner per 144G.83 Subd. 3 (2): -Option one: Purchase the Alzheimer's Association Person-Centered Dementia Care Training Program, which includes the essentiALZ® exam. Dementia Care Training Program & essentiALZ® Exam | alz.org. This training was developed with evidence from the Alzheimer's Association Dementia Care Practice Recommendations listed here: Alzheimer's Association Dementia Care Practice Recommendations | The Gerontologist | Oxford Academic (oup.com); -Option two: Purchase a training program recognized by the Alzheimer's Association and essentiALZ® Exam from the Alzheimer's Association. You can find Recognized Dementia Care Training Programs that have been recognized by the Alzheimer's Association as reflecting the five topic areas of the Dementia Care Practice Recommendations. Providers using these training programs are eligible to purchase essentiALZ® exams for their staff; -Option three: Purchase a curriculum review from the Alzheimer's Association and essentiALZ® Exam from Alzheimer's Association. Providers and training companies using proprietary training materials may submit their training programs for review. See the Dementia Care Training Curriculum Review page of the Alzheimer's Association website (alz.org) for a link to the Curriculum Review Guidelines; -Option four: For subscribers of EduCare,	02140		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02140	Continued From page 56 EduCare's 5-part Dementia Series and test may be used to meet the statutory requirement. For more information, see the EduCare website; -Option five: Purchase one of the HealthCare Interactive CARES Dementia Care Training options that meets the statutory requirements: -CARES Basics (four hours) CARES Advanced (6 hours) -CARES Activities of Daily Living (ADL) (four hours or 10 hours) -CARES Dementia Related Behavior (four hours) For more information, see the HealthCare Interactive Online website; and -Option six: Purchase the Clinical LMS courses from Residex, which includes eight-hour and four-hour bundles to meet the statutory requirements, as well as a two-hour bundle to meet the annual training requirements. See the Residex Clinical LMS website for more information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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	23986	A. BUILDING: _____ B. WING _____	08/27/2025

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02320	Continued From page 57 Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one unlicensed personnel (ULP-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2025, at 1:45 p.m., owner/clinical nurse supervisor (O/CNS)-B stated the licensee provided medication management services to residents. ULP-L was hired May 2, 2025, to provide direct care services to the licensee's residents. On August 26, 2025, at 6:48 a.m., the surveyor observed ULP-L verify R11's medication bubble packs (medications packaged by pharmacy) with the electronic medication administration record (EMAR), place medications in a medication cup with R11's first name and place in the top drawer of the south medication cart. Additionally, there was 12 other medication cups with a resident first name which contained medications. On August 26, 2025, at 6:50 a.m., ULP-L stated another staff member taught her to prepare the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02320	Continued From page 58 medications prior to administering. ULP-L stated her initial orientation was with the owner/clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C, and the competencies were completed with O/CNS-B. ULP-L stated she had five consistent days of training, shadowed a ULP for one day, and then worked four days with another ULP administering medications. On August 26, 2025, from 6:55 a.m. to 7:05 a.m., the surveyor observed ULP-L administer R10's morning scheduled medications from the north medication cart. ULP-L verified medications, administered medications and documented in the EMAR. On August 26, 2025, at 7:45 a.m., licensed practical nurse (LPN)-C stated the ULPs were expected to do the six rights, verify medications, administer medications, then document medications were given. On August 26, 2025, at 7:50 a.m., the surveyor, O/CNS-B and LPN-C observed the pre-dished medication cups in the south medication cart. O/CNS-B removed the medication cups from the cart. O/CNS-B stated ULP-L should not have pre-dished residents medications and ULP-L was not following policy. ULP-L was removed from administering medications to the residents for the remainder of the day. On August 26, 2025, at 1:20 p.m., the surveyor reviewed ULP-L's employee file, and verified medication administration training and competency was completed. The licensee's 7.22 Medications and Treatment Record-Documentation and Refusal policy dated	02320		

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ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02320	Continued From page 59 May 31, 2022, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after the task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	03090		

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03090	Continued From page 60 The findings include: On August 27, 2025, at 1:40 p.m., the surveyor and owner/clinical nurse supervisor (O/CNS)-B did not observe signage to disclose electronic monitoring. O/CNS-B stated the electronic signage was posted; however, was not sure why the sign was no longer posted. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ELDERWOOD OF HINCKLEY
710 SPRING LANE
Hinckley, MN 55037
Pine County
Parcel:

Phone:

License Info

License: HFID 23986

Risk:
License:
Expires on:
CFPM: BRYAN R BROWN
CFPM #: FM118841; Exp: 8/28/2026

Inspection Info

Report Number: F1016251064
Inspection Type: Full - Single
Date: 8/26/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 Duluth District Office inspection report number F1016251064 from 8/26/2025

BRYAN R BROWN
KITCHEN MANAGER

Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

ELDERWOOD OF HINCKLEY
Hinckley
County/Group: Pine County

Inspection Info

Report Number: F1016251064
Inspection Type: Full
Date: 8/26/2025
Time: 11:30 AM

Food Temperature: Product/Item/Unit: STRAWBERRIES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: GRAPES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BEEF ROAST**; Temperature Process:** Cooking
Location: OVEN at 199 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN**; Temperature Process:** Cold-Holding
Location: Walk-in Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: POTATOES**; Temperature Process:** Hot-Holding
Location: Steam Table at 185 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MIXED VEGETABLES**; Temperature Process:** Hot-Holding
Location: Steam Table at 185 Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

ELDERWOOD OF HINCKLEY
Hinckley
County/Group: Pine County

Inspection Info

Report Number: F1016251064
Inspection Type: Full
Date: 8/26/2025
Time: 11:30 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 400 PPM
Comment:
Violation Issued?: No

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