Electronically Delivered

October 13, 2025

Licensee
Agate Bay Assisted Living LLC
414 1st Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL30324016

Dear Licensee:

On August 28, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 5, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 5, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 5, 2025, found not corrected at the time of the August 28, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on August 28, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

Jessica Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30324	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGATE BAY ASSISTED LIVING LLC	414 1ST AVENUE TWO HARBORS, MN 55616

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30324016-1 On August 26, 2025, through August 28, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 5, 2025. At the time of the survey, there were seven residents; seven residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	This correction order was not reviewed during the follow up survey.	
{0 490} SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other	{0 490}		

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{0 490}	Continued From page 3 identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by:	{0 490}	This correction order was not reviewed during the follow up survey.	
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}	This correction order was not reviewed during the follow up survey.	

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{0 650}	Continued From page 4	{0 650}		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	This correction order was not reviewed during the follow up survey.	
{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	{0 680}		

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{0 680}	Continued From page 5 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	This correction order was not reviewed during the follow up survey.	
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of	{0 730}		

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{0 730}	Continued From page 6 the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	{0 730}		

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{0 730}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 730}	This correction order was not reviewed during the follow up survey.	
{0 775} SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, and email documentation the licensee failed to comply with the requirements of the Minnesota State Fire Code and provide compliant emergency escape and rescue openings. This had the potential to directly affect more than a limited number of residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: On August 26, 2025, at 7:55 a.m., documentation from housing manager (HM)-B, and licensed assisted living director/ registered nurse (LALD/RN)-A, was requested by email. On	{0 775}		

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{0 775}	Continued From page 8 August 26, 2025, at 12:12 p.m., documentation from HM-B, was received by email indicating that compliant emergency escape and rescue openings were not provided in resident sleeping rooms one, three, five, six. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping rooms five and six emergency escape and rescue clear window opening measurements were 24.25 inches wide, 24.5 inches in height and 594 square inches in openable area. During the previous survey tour on June 4, 2025, from 10:45 to 1:00 p.m., the windows were measured with HM-B and LALD/ RN-A, and the surveyor present. The windows did not meet the minimum requirements for clear opening square inch openable area. EMERGENCY ESCAPE AND RESCUE OPENINGS UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping rooms one and three, emergency escape and rescue clear window opening measurements were 24.25 inches wide, 22.5 inches in height and 546 square inches in openable area. During the previous survey tour on June 4, 2025, from 10:45 to 1:00 p.m., the windows were measured with HM-B and LALD/ RN-A, and the surveyor present. The windows did not meet the minimum requirements for clear opening square inch openable area. The surveyor explained to HM-B and LALD/ RN-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.	{0 775}		

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{0 775}	Continued From page 9 Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. In an email received on August 28, 2025, at 11:37 a.m., documentation was provided by HM-B, indicating building permit and approval applications were submitted and the facility is waiting for approval from the local building code authority before beginning the work to complete corrections to the non-compliant emergency escape and rescue openings in resident rooms one, three, five, and six. No further information was provided.	{0 775}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	{0 780}		

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{0 780}	Continued From page 10 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:	{0 780}	Not reviewed during this survey.	
{0 800} SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and	{0 810}		

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{0 810}	Continued From page 11 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 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:	{0 810}		

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{0 810}	Continued From page 12	{0 810}	Not reviewed during this survey.	
{01420} SS=F	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:	{01420}	This correction order was not reviewed during the follow up survey.	
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	{01620}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01620}	Continued From page 13 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 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	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30324	A. BUILDING: _____ B. WING _____	R 08/28/2025

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{01620}	Continued From page 14 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	This correction order was not reviewed during the follow up survey.	
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}	This correction order was not reviewed during the follow up survey.	
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	{01890}		

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{01890}	Continued From page 15 drug. This MN Requirement is not met as evidenced by:	{01890}	This correction order was not reviewed during the follow up survey.	
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	This correction order was not reviewed during the follow up survey.	
{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:	{03090}	This correction order was not reviewed during the follow up survey.	

Electronically Delivered

August 6, 2025

Licensee
Agate Bay Assisted Living LLC
414 1st Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL30324016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 5, 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 $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

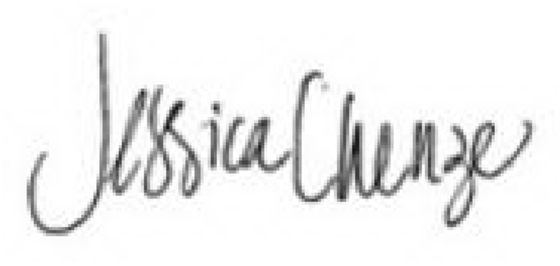
may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30324	A. BUILDING: _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30324016-0 On June 3, 2025, through June 5, 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 7 residents; 7 residents receiving services under the Assisted Living Facility license. An immediate correction order was identified on June 3, 2025, for tag identification 1290. The facility took mitigating action to address the violation. Noncompliance remains at a scope and level of widespread, three (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June, 5, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental,	0 490		

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0 490	Continued From page 4 and psychosocial needs available to residents. This had the potential to affect all residents 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 June 3, 2025, at 9:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and housing manager (HM)-B stated the licensee provided bingo weekly and offered one on one activities for the residents; however, the licensee did not offer a daily program of social and recreational activities for the residents. During the facility tour on June 3, 2025, at 10:48 a.m., with HM-B, there was no daily calendar of activities posted or available for the residents. During the course of the survey, from June 3, 2025, through June 5, 2025, the surveyor observed one scheduled music activity for the licensee's residents on June 3, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		

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0 640	Continued From page 5	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required 911 emergency number in common areas at the assisted living. 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) 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: During the facility tour on June 3, 2025, at 10:48 a.m., with housing manager (HM)-B, the surveyor did not observe 911 emergency number posted in any common areas, or near phones at the	0 640		

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0 640	Continued From page 6 assisted living. HM-B stated they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee	0 650		

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0 650	Continued From page 7 records contained the required content for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 3, 2025, at 9:52 a.m., housing manager (HM)-B stated the licensee was familiar with the required content of employee records and HM-B was identified as responsible for maintaining employee records. LALD-/CNS-A LALD/CNS-A's had a hire date of February 1, 2021, under the comprehensive home care license and began to provide assisted living services on August 1, 2021. During the course of the survey, the surveyor observed LALD/CNS-A provide care and services to the licensee's residents. LALD/CNS-A's record included an annual performance review dated June 8, 2023. LALD/CNS-A's record lacked evidence an annual performance review had been completed since 2023. In addition, LALD/CNS-A's record included a completed two step Mantoux tuberculosis (TB) test on August 12, 2020, however, lacked	0 650		

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0 650	Continued From page 8 evidence a TB history and screening had been completed upon hire as required. ULP-E ULP-E had a hire date of July 15, 2024, to provide direct care services to the licensee's residents. On June 4, 2025, at 7:51 a.m., the surveyor observed ULP-E administering R4's morning medications and monitor R4's blood glucose (sugar). On June 4, 2025, at 1:46 p.m., LALD/CNS-A stated they could not find TB history and screening questionnaires for LALD/CNS-A and ULP-E. In addition, LALD/CNS-A stated there was no annual performance review completed in 2024 for LALD/CNS-A, because LALD/CNS-A was unsure who would perform the annual performance review since LALD/CNS-A was part-owner, LALD and CNS. The licensee's Personnel Records policy dated January 2021, indicated personnel records would be kept up to date, well organized and would comply with the home car law and other relevant laws. A personnel file would include, but not limited to: -TB screening results; and -annual performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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	30324	A. BUILDING: _____ B. WING _____	06/05/2025

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post an emergency preparedness plan prominently with all the required content. 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	0 680		

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0 680	Continued From page 10 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 3, 2025, at 9:52 a.m., licensed assisted living director/clinical nurse manager (LALD/CNS)-A and housing manager (HM)-B stated the licensee's emergency preparedness plan had not been fully developed and was in working progress. During the facility tour on June 3, 2025, at 10:48 a.m., with HM-B, the surveyor did not observe the licensee's emergency preparedness plan or a sign indicating location of the EPP in common areas of the building. HM-B stated they were unaware of the requirement. The licensee's undated emergency preparedness plan lacked the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document	0 680		

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0 680	Continued From page 11 locations or residents and staff - emergency staff strategies - the facility's role in providing care and treatment at alternative sites - a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman - 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 emergency plan with residents and their families - EP testing/annual testing requirements. The licensee's Plans for Natural Disasters and Emergencies policy dated February 2021, indicated the licensee would have a written plan of action to facilitate the care and services in response to natural disaster or another type of emergency that may affect the ability to provide services. The plan would be updated regularly and would be coordinated with local emergency responders, and where appropriate, with the management and of senior housing buildings where the clients live. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 12	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 13 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure delegated tasks were administered as directed and failed to document the reason they were not administered for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included heart failure, diabetes type two, anxiety, depression and glaucoma. R2's Service Plan dated December 2, 2025, directed to refer to R2's Treatment Management plan for treatment/therapy services. R2's Client Treatment or Therapy Management Plan dated October 1, 2024, indicated the licensee would weigh R2 every morning and	0 730		

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0 730	Continued From page 14 notify the registered nurse (RN) if R2's weight increased three pounds (lbs) on one day or five lbs in one week. R2's record did not indicate weight monitoring was prescriber ordered. R2's Treatment Record dated May 1, 2025, through May 31, 2025, indicated there were 10 out of 31 opportunities R2's weight was not monitored and recorded or documentation reason why R2's weight was not monitored as directed. On June 3, 2025, at 4:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed R2's Treatment Record and stated staff should have documented a reason why R2's weight was not monitored for the days there were no recorded weight in R2's treatment record. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks dated February 2021, indicated before delegating or assigning a task to unlicensed personnel (ULP), the RN would determine that each staff member who perform the task were trained and competent to perform the task and instructed in the proper procedures for performing the procedure. Each ULP would sign off to attest the written instructions in the client's file that they have read and understand the instructions prior to providing the service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		

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0 775	Continued From page 15	0 775		
0 775 SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code and provide compliant emergency escape and rescue openings. This had the potential to directly affect more than a limited number of residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: On a facility tour on June 4, 2025, from 10:45 a.m. to 1:00 p.m., with housing manager (HM)-B and licensed assisted living director/ registered nurse (LALD/RN)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms five, six. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping rooms five and six emergency	0 775		

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0 775	Continued From page 16 escape and rescue clear window opening measurements were 24.25 inches wide, 24.5 inches in height and 594 square inches in openable area. The windows were measured with HM-B and LALD/ RN-A, and the surveyor present. The windows did not meet the minimum requirements for clear opening square inch openable area. The surveyor explained to HM-B and LALD/ RN-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by HM-B and LALD/ RN-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. In addition, the following violations were identified during the survey with a time period for correction that was not immediate. Findings include: On a facility tour on June 4, 2025, from 10:45 a.m. to 1:00 p.m., with housing manager (HM)-B,	0 775		

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0 775	Continued From page 17 the surveyor made the following observations of non-compliance with emergency escape and rescue opening minimum clear opening size and the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EMERGENCY ESCAPE AND RESCUE OPENINGS UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping rooms one and three, emergency escape and rescue clear window opening measurements were 24.25 inches wide, 22.5 inches in height and 546 square inches in openable area. The window was measured with HM-B and LALD/ RN-A, and the surveyor present. The windows did not meet the minimum requirements for clear opening square inch openable area. It was explained to HM-B and LALD/ RN-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. DISPENSING OF USED SMOKING MATERIALS There was a plastic water bottle used to dispense used cigarette butts outside the third floor office door on the exterior wood deck. It was explained to HM-B, that used smoking materials are required to be dispensed in metal containers in accordance with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE The smoke alarms were removed by HM-B, in resident rooms seven, eight and in the utility/	0 775		

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0 775	Continued From page 18 mechanical basement to observe date of manufacture. It was observed the manufacture date identified on the smoke alarms were 2006. There were smoke alarms not functional in addition to the functional required alarms in the main floor entry way near resident sleeping room six, in storage room near resident sleeping room ten, and several other locations in the facility. It was explained all smoke alarms when installed are required to be maintained in accordance with MSFC in Minnesota Rules Chapter 7511 and replaced within ten years of the date of manufacture. EXIT/ EMERGENCY LIGHTING The exit signs above the door in the corridor outside resident room five and leading outside to the back main floor deck were not lit at all times building is occupied. The exit signs were also tested by activating the test button and did not function as required to provide backup power for lighting of the exit sign in the event of a power outage. MARKED EXTERIOR-INTERIOR EXIT PATH STAIRWAY GUARDRAILS/ HANDRAILS The marked exterior exit stairways were missing a guardrail on one side leading off to ground level from the back main floor deck and the stairway leading from the third-floor deck down to the second floor back deck. The exit stairway leading to an exit from the third floor office space was open on one side with no guardrail provided next to the walking surface between the office wall and stairway.	0 775		

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0 775	Continued From page 19 It was explained to HM-B, that the open side of marked exit stairways are required to be provided with a guardrail in compliance with MSFC in Minnesota Rules Chapter 7511 in order to prevent occupant falls while exiting the building in the event of a fire or similar emergency. The marked exterior exit stairways were not provided with a graspable handrail for occupants use while exiting during a fire or similar emergency leading from the decks on third floor to second floor, from second floor to main floor, and from main floor to ground. It was explained to HM-B, that the open side of marked exit stairways are required to be provided with a graspable handrail in compliance with MSFC in Minnesota Rules Chapter 7511 in order to prevent occupant falls while exiting the building in the event of a fire or similar emergency. ELECTRICAL BOX COVERS The surveyor observed an electrical junction box with the cover missing under the main floor exterior back deck, in the basement utility/ mechanical room on the ceiling above the laundry sink and on the light switch in the third-floor office. It was explained to HM-B that electrical boxes containing electrical connections are required to be provided with a cover. ELECTRICAL EXTENSION CORDS There was an electrical extension cord installed with electrical straps under the main back exterior deck.	0 775		

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0 775	Continued From page 20 There was an electrical extension cord used as permanent power supply and attached to the building for the sump pump in the basement near the washer and dryer. It was explained to HM-B, that electrical extension cords shall be used only for temporary power supply and not installed or fastened to the building structure in accordance with MSFC in Minnesota Rules Chapter 7511. EXIT PATH DOOR HANDLE MAINTENANCE The door leading into resident sleeping room one did not have a door handle installed in order to exit the room in the event of a fire or similar emergency. STORAGE IN FRONT OF ELECTRICAL PANEL There was storage blocking access to the electrical panel in the storage room near resident sleeping room ten. It was explained to HM-B, that all electrical panels shall be kept clear of obstructions to access to the electrical panel. These deficient conditions were visually verified by HM-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 21 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except 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 interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 22 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: INTERCONNECTION On a facility tour on June 4, 2025, from 10:45 a.m. to 1:00 p.m., with housing manager (HM)-B, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility in the resident rooms and the hallways. It was explained to HM-B, that smoke alarms in the facility are required to be interconnected so if one alarm is activated all alarms are activated in the hallways and resident rooms and independent of the fire alarm system. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and HM-B, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms in the resident rooms and the hallways throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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AGATE BAY ASSISTED LIVING LLC	414 1ST AVENUE TWO HARBORS, MN 55616

(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
0 800	Continued From page 23 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. 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 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). Findings include: On a facility tour on June 4, 2025, from 10:45 a.m. to 1:00 p.m., with housing manager (HM)-B, the surveyor made the following observations of facility disrepair: PLUMBING SYSTEM MAINTENANCE	0 800		

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0 800	Continued From page 24 There was a temporary repair completed and installed above ground for the underground main sewer pipe in the mechanical/ utility room basement. There was an open drainpipe not sealed to prevent sewer gas from entering the building in the back exit area to the back exterior deck. ROOF COVERING MATERIAL MAINTENANCE The roof covering material was deteriorated from the elements and crumbling off the roof over the sunroom attached to the back of the kitchen. CEILING FINISH MATERIAL MAINTENANCE The was a three foot by three-foot piece of ceiling plaster material that fell off the ceiling in resident sleeping room one. WATER HEATER MAINTENANCE The water heater was leaking, and water was present on the floor in the boiler room near resident sleeping room ten. During the facility tour HM-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 25 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 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 4, 2025, at 9:25 a.m., housing manager (HM)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The FSEP evacuation floor plan map was posted in a conspicuous location on the main floor but was not posted on in the two separate basements, on the second floor or the third floor. It was explained to HM-B, that the evacuation floor plan is required to be posted in a conspicuous location on all floor levels. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and	0 810		

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0 810	Continued From page 27 evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on June 4, 2025, at 9:50 a.m., HM-B, stated resident procedures to take in the event of a fire or similar emergency were not included in writing in the FSEP. HM-B, also stated resident evacuation status/ unique needs for evacuation for each resident was not kept in writing and readily available for use in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation training was provided annually to residents as required. During an interview on June 4, 2025, at 10:10 a.m., HM-B, stated documentation was not available indicating residents were provided training annually as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in March, April and December of 2024 only and were completed as training and not drills.	0 810		

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0 810	Continued From page 28 During an interview on June 4, 2025, at 10:15 a.m., HM-B, stated the documentation provided for fire drills was for training provided to staff and they were confused of the requirements for fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of nine employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents living within the facility.	01290		

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01290	Continued From page 29 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: This resulted in an immediate correction order on June 3, 2025. During the entrance conference on June 3, 2025, at 9:52 a.m., housing manage (HM)-B stated the licensee was aware of required contents in an employee record. ULP-D was hired on October 20, 2023, to provide direct care services to residents at the facility. R2's May 2025 Treatment Record included ULP-D's initials indicating ULP-D monitored R2's weight, blood glucose and assisted R2 with personal cares on the following days; -May 3, 10 17, 24, and 31, 2025. The licensee's weekly schedule dated June 2, 2025, to June 15, 2025, indicated ULP-D was scheduled to work June 14, 2025, from 7:00 a.m., to 3:30 p.m. The licensee's DHS NETStudy Roster with healthcare facility identification (HFID) 30324 printed on June 3, 2025, indicated ULP-D was not listed as a current employee.	01290		

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01290	Continued From page 30 ULP-D's employee record lacked a current cleared background study. On June 3, 2025, at 2:29 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and HM-B stated they were unsure why ULP-D did not have a DHS Background Clearance letter in ULP-D's employee file. HM-B stated ULP-D had taken a leave of absence from July 2024, to December 2024, and was unsure if ULP-D had been removed from the licensee's NETStudy Roster. The licensee's Personnel Records dated January 2021, indicated a personnel file would be maintained and would include documentation of a completed criminal background study. 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	01290		

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01290	Continued From page 31 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 The licensee too mitigating actions on June 3, 2025, however, noncompliance remains at a scope and level of I.	01290		
01420 SS=F	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) ensured training and competency demonstrations were completed for	01420		

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01420	Continued From page 32 three of three employees (housing manager (HM)-B, unlicensed personnel (ULP)-D, ULP-E) for the use of a motorized stairlift chair. Additionally, the RN failed to provide written instructions in the resident records for one of one resident (R4) who utilized a motorized stairlift chair. 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 finding include: During the facility tour with housing manager (HM)-B, on June 2, 2025, at 11:11 a.m., the surveyor observed a motorized chairlift installed on tracks from the first floor to the second floor located in the foyer of the facility. HM-B stated the licensee had one resident (R4) who utilized the chairlift to get from the second floor to the main level. R4's diagnoses included diabetes, cognitive decline, chronic pain syndrome, chronic kidney disease stage III and bradycardia (low heat rate). R4's comprehensive assessment dated April 15, 2025, indicated R4 required the use of a walker for ambulation and was independent with transfers. R4's vulnerability and safety assessment dated April 15, 2025, did not include the use of a	01420		

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01420	Continued From page 33 motorized stairlift to ambulate from the second story to the main level of the facility. R4's care plan dated April 1, 2025, and R4's Service Plan dated April 30, 2025, indicated R4 required assist of one getting up from a chair, bed, toilet, and required stand by assist with ambulation with walker and wheelchair. Staff were to support and encourage R4 with independence per R4's capabilities. R4's care plan did not indicate R4 required the use of a motorized stairlift to get from the second floor to the main level of the facility, nor did R4's record include written instructions from RN. HM-B had a hire date of February 1, 2021, to provide care and services to the licensee's residents. On June 5, 2025, at 10:48 a.m., the surveyor observed HM-B assist R4 with the motorized chairlift. R4 operated the control of the motorized chair while HM-B walked along side of R4 during the descend from the second floor to the main level of the facility. ULP-D had a hire date of October 23, 2023, to provide care and services to the licensee's residents. ULP-E had a hire date of July 15, 2024, to provide care and services to the licensee's residents. HM-B, ULP-D and ULP-E's employee records lack training and competency evaluations for the use of a motorized stairlift chair. On June 5, 2025, at 9:20 a.m., licensed assisted living director/clinical nurse manager	01420		

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01420	Continued From page 34 (LALD/CNS)-A and HM-B stated staff had not been trained on the use of the motorized stairlift chair and did not think of the stairlift as a transfer device. LALD/CNS-A stated R4's record did not include the use of the motorized stairlift including any written directions for use. HM-B stated the motorized stairlift was installed by the previous owner and the licensee did not have manufacturer instructions on use. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated November 2020, indicated unlicensed personnel would meet all orientation and training requirements and would be determined to be competent to perform all assigned tasks by the RN or other Licensed Health Professional, when appropriate, before unlicensed personnel may provide service to the licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	01620		

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01620	Continued From page 35 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 36 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment to include motion and pressure alarms being utilized for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included heart failure, diabetes type two, anxiety, depression and glaucoma. On June 4, 2025, at 10:22 a.m., during a medication administration with ULP-E, the surveyor observed a motion sensor alarm being used in R2's room. R2's Service Plan dated May 2, 2025, indicated R2 required assistance with activities of daily living including bathing, dressing, bed mobility, transfers, and toileting. R2's comprehensive assessment April 2, 2025, indicated R2 required assistance with dressing, grooming, bathing, bed mobility, transfers, toileting, medication administration, and blood glucose monitoring; however, lacked an assessment of the use or need of a motion sensor alarm.	01620		

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01620	Continued From page 37 R2's Care Plan dated April 2, 2025, indicated R2 had a history of falls and motion sensors were in R2's room to alert staff when R2 attempted to get out of bed or chair. R3 R3's diagnosis included dementia. On June 4, 2025, at 8:00 a.m., during R3's observation of morning cares and transfer assist with ULP, the surveyor observed a pressure alarm on R3's bed and a motion alarm in R3's room. ULP-C stated both alarms were activated with motion to alert staff if R3 attempted to get out of the bed or chair. ULP-C stated there was no place in R3's chart to document sensor alarms were put in place. R3's Service Plan dated November 26, 2024, indicated R3 required assistance with activities of daily living including transfers and bed mobility. R3's comprehensive assessment dated April 20, 2025, indicated R3 required assistance with transfers, bed mobility, and had a history of falls. R3's Care Plan dated April 22, 2025, indicated R3 required assistance with medication administration, dressing, bathing, grooming, transferring with the use of a mechanical device, toiling, and safety. Staff were to ensure R3's sensor alarms were always on in R3's room and bed alarm used during the hours of sleep. R2 and R3's June 2025 Services Delivery Records did not direct the application of R2 and R3's pressure or motion sensor alarms. On June 4, 2025, at 11:40 a.m., licensed assisted	01620		

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	30324	A. BUILDING: _____ B. WING _____	06/05/2025

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01620	Continued From page 38 living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee did not address motion sensor or pressure alarms in resident assessments or included in resident's service delivery records. LALD/CNS-A stated motion and pressure alarms should be addressed in resident assessments for care planning interventions and included in the resident service delivery record to ensure staff were implementing the alarms. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated November 2020, indicated an RN would complete a nursing assessment and the assessment would be the basis for the service plan that the RN would recommend to the resident and the basis for the care plan and staff to follow when implementing the resident services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 39 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per the manufacturer's instructions for one of one residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnosis included diabetes type II. R2's Service Plan dated December 2, 2025, indicated R2 received medication administration. On June 4, 2025, at 10:22 a.m., the surveyor observed unlicensed personnel (ULP)-E dial up 24 units of Lantus (long-acting) insulin and administer into the back of R2's left arm. ULP-E did not prime the Lantus insulin pen two units prior to dialing prescribed dose and administering to R2. ULP-E stated they were instructed by the registered nurse (RN) not to prime insulin pens two units. R2's prescriber orders dated March 20, 2025, and May 19, 2025, included Lantus SoloStar	01760		

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01760	Continued From page 40 (long-acting) insulin 24 units in the morning and 12 units at bedtime as directed. R2's May and June 2025 Medication Administration Record (MAR) included staff initials indicating R2 received Lantus SoloStar insulin daily as scheduled. R2's record did not indicate to prime Lantus insulin pen two units prior to dialing prescribed dose. R5 R5's diagnosis included diabetes type II. On June 3, 2025, at 12:06 p.m., the surveyor observed ULP-C administering R5's Humalog (fast-acting) insulin into R5's left abdomen. ULP-C stated they had been instructed by LALD/CNS-A they were no longer required to prime insulin pens two units prior to administration. On June 4, 2025, at 2:20 p.m., licensed assisted living director/clinical nurse manager (LALD/CNS)-A stated LALD/CNS-A was told by a pharmacist pre-filled insulin pens no longer needed to be primed two units before dialing prescribed dose. LALD/CNS-A reviewed the licensee's insulin administration policy and manufacturer's directions for Lantus insulin and stated both directed to prime insulin pen two units prior to dialing prescribed dose. LALD/CNS-A stated maybe the information received by the pharmacist was misinterpreted and only pertained to certain insulin pens that did not need to be primed two units.. LALD/CNS-A stated staff would be retrained on priming insulin pens if directed by the manufacture. The manufacturer's instructions for Lantus SoloStar insulin pen dated June 2022, indicated	01760		

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01760	Continued From page 41 to dial two units of insulin, discard then dial prescribed dose for administration. The manufacturer's instructions for Humalog KwikPen insulin dated July 2023, indicated to prime the insulin pen two units to ensure proper dosing before administration. The licensee's Insulin Administration policy dated February 2021, indicated the purpose of the policy was to assist staff with accurately and safely administration per RN delegation and manufacturer's instructions per insulin pen. Insulin procedure directed to prime the pen per manufacturer guidelines, then dial the correct dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with a legible prescription label and information including the opened date and expiration date for time sensitive medications for	01890		

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01890	Continued From page 42 one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 June 3, 2025, at 10:58 a.m., the surveyor toured the medication storage room with housing manager (HM)-B and observed the following: -R2's opened Lantus (long-acting) Solostar pre-filled insulin pen lacked the date the insulin had been opened and when the insulin pen would expire; -R2's opened latanoprost's 0.005% eye drop (decreases eye pressure) lacked the date the eye drop had been opened and when the eye drop would expire: and -R2's opened levobunolol (Betagan) HCl 0.5% eye drop (decreases eye pressure) lacked the date the eye drop had been opened and when the eye drop would expire. R2's diagnoses included diabetes type II, glaucoma and heart disease. R2's Service Plan dated December 2, 2025, indicated R2 received medication administration and storage. R2's prescriber orders dated March 20, 2025, and May 19, 2025, included levobunolol eye drop every morning daily, latanoprost 0.0005% eye drop at bedtime and Lantus Solostar insulin 24	01890		

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01890	Continued From page 43 units in the morning and 12 units at bedtime as directed. R2's May and June 2025 Medication Administration Record included staff initials indicating R2 received levobunolol and latanoprost eye drops and Lantus Solostar insulin daily as scheduled. On June 4, 2025, at 2:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff had been trained to date insulins when opened and would expire. LALD/CNS-A staff have not been trained on dating other time-sensitive medications such as eye drops and inhalers when opened and had not previously thought about it. The manufacturer's instructions for Lantus Solostar insulin pens dated June 2022, indicated to discard 28 days after opened even if it still has insulin left in it. The manufacturer's instructions for latanoprost eye drop dated August 2011, indicted to discard eye drop six weeks after first opened. The manufacturer's instructions for levobunolol eye drop dated December 2017, indicated to discard eye drop four weeks after first opened. The licensee's Storage of Medications policy dated February 1, 2021, indicated medications must be kept original container bearing the original prescription label with legible information stating the expiration date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 44 days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R4) who utilized a motorized stairlift for transfers. In addition, the licensee failed to ensure the steps of the medication administration process was followed for two of two unlicensed personnel (ULP-E, and ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MOTORIZED STAIRLIFT During the facility tour with housing manager (HM)-B, on June 2, 2025, at 11:11 a.m., the	02310		

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02310	Continued From page 45 surveyor observed a motorized stairlift installed on tracks connecting the first floor to the second floor of the facility. HM-B stated the licensee had one resident (R4) who utilized the chairlift to get from the second floor where R4's room was located to the main level of the facility. R4's diagnoses included diabetes, cognitive decline, chronic pain syndrome, chronic kidney disease stage III, and bradycardia (low heat rate). R4's Service Plan dated April 30, 2025, indicated R4 required assist of one getting up from a chair, bed, toilet, and required stand by assist with ambulation with walker and wheelchair. R4's comprehensive assessment dated April 15, 2025, indicated R4 required the use of a walker, was independent with transfers and required the physical assistance of one to evacuate in an emergency. R4's assessment did not indicate R4 required the use of a motorized chairlift to get from the second floor of the facility to the main level. R4's vulnerability and safety assessment dated April 15, 2025, did not include R4's use of a motorized stairlift to safely transfer from the second story to the main level of the facility. R4's care plan dated April 1, 2025, indicated R4 required assist of one getting up from a chair, bed, and toilet and required stand by assist with ambulation with with walker and wheelchair. Staff were to support and encourage R4 with independence per R4's capabilities. R4's care plan did not indicate, R4 required the use of a motorized stairlift to get from the second floor to the main level of the facility.	02310		

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02310	Continued From page 46 On June 5, 2025, at 10:48 a.m., the surveyor observed HM-B assist R4 get into the motorized chairlift. R4 operated the control of the motorized chair while HM-B walked along side of R4 during the descend from the second floor to the main level of the facility. HM-B stated R4 would not be able to use the stairs and exit the facility without the use of the motorized chairlift.. ULP-F stated R4 used the motorized stairlift to get from the second floor where R4's room was located to the main level. ULP-F stated R4 used the stairlift at a minimum once a week for showers, which was located on the main level of the facility. On June 5, 2025, at 9:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the previous owner had the chairlift installed and the licensee did not have the manufacturer operating directions for use. LALD/CNS-A stated the licensee had a contract with an elevator company for regular inspections of the chairlift. LALD/CNS-A stated R4 had not been assessed for the chairlift use and R4's record did not indicate R4's need to use a motorized chairlift for transfers to get from the second floor to the main level of the facility. LALD/CNS-A stated LALD/CNS-A had not considered the chairlift a transfer device. In addition, LALD/CNS-A stated the licensee's staff have not been trained on the operations of the stairlift and would incorporate into staff's required training. The Assessment Regarding Safe Use of Assistive Devices policy dated February 2021, indicated the registered nurse's initial assessment and re-assessments would include an evaluation of a resident's ability to safely use any Assistive	02310		

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02310	Continued From page 47 device. The registered nurse (RN) would work with the housing manager to develop any safety procedures or house rules related to assistive devices needed to improve the safety of all residents and residents in the building. MEDICATION ADMINISTRATION During the entrance conference on June 3, 2025, at 9:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents. R2's diagnoses included diabetes, diabetic neuropathy, history of left hip replacement, and anxiety. R2's Service Plan dated December 2, 2025, indicated R2 received medication administration services. On June 4, 2025, at 10:22 a.m., the surveyor observed three ULP in R2's room (ULP-E, ULP-G, and ULP-C). ULP-E was observed to monitor R2's blood glucose (sugar) and administer R2's Lantus insulin. The surveyor observed an opened lidocaine package and a tube of Voltaren cream in a clear plastic baggie on R2's nightstand. ULP-E asked ULP-G if ULP-G had applied R2's lidocaine patch (used for pain) or Voltaren cream (used for pain) and ULP-G replied ULP-G did not know where to apply R2's cream or patch. ULP-E left R2's patch and cream on the nightstand for administration and exited R2's room. ULP-G proceed to assist R2 with dressing then summoned ULP-C for transfer assistance. ULP-C and ULP-E assisted R2 to a standing position and ULP-C provided incontinent care and transferred R2 into the	02310		

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02310	Continued From page 48 wheelchair. ULP-C applied R2's lidocaine patches to R2's back. R2's lidocaine patch had been opened with ULP-E's initials and dated for June 4, 2025, which indicated ULP-E had set up R2's lidocaine patch which was admitted by another ULP. R2's June Medication Administration Record-PRN date included ULP-E's initials on June 4, indicating ULP-E administered R2's lidocaine patch at 10:45 a.m. ULP-E had a hire date of July 15, 2024, to provide direct care services to the licensee's residents. ULP-E's training transcripts indicated ULP-E completed medication administration training on July 29, 2025. In addition, ULP-E's employee record included a skills checklist indicating ULP-E demonstrated competency in medication administration to the RN on July 31, 2024. On June 4, 2025, at 2:20 p.m., LALD/CNS-A stated staff were not allowed to prepare medications and allow another staff to administer. LALD/CNS-A stated staff have been trained to prepare the residents, administer, and document the administration in the resident record. On June 5, 2025, at 11:00 a.m., ULP-C stated ULP-C should not have applied R2's lidocaine patches after ULP-C realized ULP-E had initialed and dated the lidocaine patches and then later found ULP-E had singed R2's MAR that ULP-E administered the patches. The licensee's Administration of Medications by Unlicensed Personnel policy dated February 2021, indicated after ULPs satisfied the training	02310		

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02310	Continued From page 49 requirements and have been determined competent by the RN may administer medications. ULPs would prepare the medications, administer the medication to the resident, and document the administration of medications in the MAR. The licensee's Administration and Documentation of PRN Medications policy dated August 2021, indicated staff would administer PRN medications as prescribed and document administration of PRN medications on the required form. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
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.	03090		

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03090	Continued From page 50 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). The findings include: During the facility tour on June 3, 2025, at 10:48 a.m., with housing manager (HM)-B, the surveyor did not observe signage to disclose electronic monitoring. HM-B stated the licensee did not have electronic monitoring within the building so the licensee did not think they were required to post electronic monitoring signage. 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

Agate Bay Assisted Living LLC
414 1st Avenue
Two Harbors, MN 55616
Lake County
Parcel:

Phone:

License Info

License: HFID 30324

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

Inspection Info

Report Number: F7980251014
Inspection Type: Full - Single
Date: 6/5/2025 Time: 10:45:35 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 2-100 Supervision
2-102.11D,E,F,G,H,I *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.
COMMENT: COOK DID NOT KNOW COOKING TEMPERATURE FOR EGG BAKE. FOOD WAS COOKED CORRECTLY BUT STAFF MUST BE TRAINED ON PROPER MINIMUM COOKING TEMPERATURES. HANDOUTS WILL BE EMAILED WITH THE REPORT.
Comply By: 6/5/2025 Originally Issued On: 6/5/2025

New Order: 2-300 Personal Cleanliness
2-301.15 *Priority Level: Priority 2 CFP#: 8*
MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.
COMMENT: A DUAL BASIN SINK IS PROVIDED. LABEL THE RIGHT SIDE AS HANDWASHING AND LEFT SIDE FOR FOOD PREP. WASH HANDS ONLY IN THE RIGHT SIDE. STAFF WASHED HANDS IN BOTH SINKS DURING INSPECTION.
Comply By: 6/5/2025 Originally Issued On: 6/5/2025

New Order: 4-200 Equipment Design and Construction
4-203.11 *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0555 Replace food temperature measuring devices that are not accurate to plus or minus 2 degrees F.
COMMENT: THEMOMETER IN BASEMENT REFRIGERATOR READ 26F WHEN FOOD WAS 38F. ALWAYS TAKE TEMPERATURE OF THE FOOD TO VEFIRY THAT AIR THERMOMETER IS ACCURATE. AIR TEMP SHOULD BE 35F OR BELOW TO KEEP FOOD BELOW 41F
Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Food & Beverage General Comment

Notes
1. HRD inspection with nurse evaluator Sativa Bushey
2. Facility keeps food temperature logs for refrigerators, always take food temperatures not air temperatures for the log.

3. Thermo labels are available for the dish machine. Ensure staff test the dish machine daily as you would any other sanitizer
4. Illness log provided for kitchen staff, anyone with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop and illness is recorded in the log. Illness information will be emailed with the report.
5. Food safety fact sheet will be emailed with the report. It is recommended to post the required food temperatures in the kitchen for staff these can be found at the bottom of our temperature log.
6. Thin probe thermometer provided, calibrate the thermometer at least monthly. Always calibrate if the thermometer is dropped. Fridge thermometers must be replaced if dropped.

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 F7980251014 from 6/5/2025

Samantha

Sara Bents

Sara Bents,
Public Health Sanitarian 3
218-302-6184
sara.bents@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Agate Bay Assisted Living LLC
Two Harbors
County/Group: Lake County

Inspection Info

Report Number: F7980251014
Inspection Type: Full
Date: 6/5/2025
Time: 10:45:35 AM

Food Temperature: Product/Item/Unit: Grapes**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: Basement fridge
Violation Issued?: No

Food Temperature: Product/Item/Unit: Shredded cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: basement fridge
Violation Issued?: No

Food Temperature: Product/Item/Unit: Lunch meat**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: basement fridge
Violation Issued?: No

Food Temperature: Product/Item/Unit: All items frozen hard**; Temperature Process:** Cold-Holding
Location: Upright Freezer at Degrees F.
Comment: All freezers frozen hard
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cottage cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: Kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Orange Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment: Kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Lunch meat**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment: kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Quiche**; Temperature Process:** Cooking
Location: Oven at 203 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Onions and pepper**; Temperature Process:** Cooking
Location: Stove at 178 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

Agate Bay Assisted Living LLC
Two Harbors
County/Group: Lake County

Inspection Info

Report Number: F7980251014
Inspection Type: Full
Date: 6/5/2025
Time: 10:45:35 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment: Sanitizer wipes
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F7980251014

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	2	Date: 6/5/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:45:35 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Agate Bay Assisted Living LLC	414 1st Avenue	Two Harbors, MN	55616	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30324		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	OUT	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	OUT	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	N/A	Proper reheating procedures for hot holding		
20	N/A	Proper cooling time and temperature		
21	N/A	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/A	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Sara Bents

Follow-up: Follow-up Date: