Electronically Delivered

June 25, 2025

Licensee
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721

RE: Project Number(s) SL30400016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/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

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
	30400	A. BUILDING: _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

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0 000	Initial Comments 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: SL30400016 On May 5, 2025, through May 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 470		

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0 470	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of 12 residents, and had a current census of 12 residents. On May 5, 2025, at 10:03 a.m., during the entrance conference, with licensed assisted living director (LALD)-A, licensed practical nurse (LPN)-B, and clinical nurse supervisor (CNS)-C, CNS-C stated she developed the staffing plan. CNS-C stated the staffing plan was evaluated at least twice yearly. CNS-C and LPN-B stated the daily staff scheduled was: - three unlicensed personnel (ULP) worked from 6:30 a.m. until 3:00 p.m., and added one ULP might leave between 1:00 p.m. and 2:00 p.m. - two ULP worked from 3:00 p.m. until 11:00 p.m. - one ULP worked from 11:00 p.m. until 7:00 a.m. On May 5, 2025, at 11:43 a.m., the surveyor reviewed the facility's staffing plans dated September 1, 2024, and March 1, 2025, respectively, and daily work schedule for staffing, dated September 1, 2024, and March 1, 2025, which noted: Staffing Plan - the LALD and CNS of (name of licensee/ not licensed in dementia care) would review and implement the staff schedule to ensure we (licensee) provide an adequate number of direct-care staff that can meet the resident's needs 24 hours a day, seven days a week. Twice a year staffing plan will be evaluated and changed as necessary by LALD and CNS. - scheduling of direct care staff will depend on our	0 470		

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0 470	Continued From page 3 resident census; staff will be adjusted as needed depending on the amount and needs of residents. The design of the building will be taken into consideration - experience, training, and competency of the direct care staff will be reviewed and taken into account with scheduling. One staff is available at the facility on night shift and there will be staff close by seven days a week if a two-person transfer is needed. More staff will be hired if the census requires an increase in care. Daily work schedule for staffing - resident aide (ULP): 6:30 a.m. through 3:00 p.m. - resident aide: 6:30 a.m. through 3:00 p.m. - resident aide: 6:30 a.m. through (no time indicated) - resident aide: 3:00 p.m. through 11:00 p.m. - resident aide: 3:00 p.m. through (no time indicated) - resident aide: 11:00 p.m. through 7:00 a.m. LALD: Monday through Friday 8:00 a.m. through 3:00 p.m., (also as needed/PRN) LPN: Monday through Friday 9:00 a.m. through 3:00 p.m., (also PRN) RN (registered nurse/CNS): Monday through Friday 11:00 a.m. through 5:00 p.m., (also, PRN). Directly after the above review, CNS-C stated there were no metric used to determine the facilities staffing needs. CNS-C pointed to her head and stated the metric was in her head. CNS-C stated it made sense to have a metric to determine staffing needs. The licensee's Staffing & Scheduling policy noted August 4, 202 (sic), noted the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the	0 470		

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0 470	Continued From page 4 resident's needs 24-hours a day, seven-days a week -the CNS must ensure that staffing levels are adequate to address the following - each resident's needs, as identified in the resident's service plan and assisted living contract - each resident's acuity level, as determined by the most reassessment or individualized review the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises - whether the facility had a secured dementia sure unit - staff experience, training, and competency. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs an according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the	0 480		

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0 480	Continued From page 5 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 allowed provided the facility keeps them clean and in good condition;	0 480		

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0 480	Continued From page 6 (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 May 5, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 7	0 510		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by two of three employees, unlicensed personnel (ULP)-F, ULP-E) while providing medication and personal care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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: ULP-F	0 510		

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0 510	Continued From page 8 ULP-F was hired on January 3, 2024, to provide direct care services to the facility's residents. On May 6, 2025, from 7:27 a.m. through 7:48 a.m., the surveyor continuously observed ULP-F. On May 6, 2025, at 7:27 a.m., the surveyor observed ULP-F use hand sanitizer and apply gloves. On May 6, 2025, at 7:28 a.m., the surveyor observed R6 lying in bed, wearing a condom catheter (external urinary catheter, worn like a condom over the penis which collects urine as it drained out of the bladder and sends the urine into a collection bag strapped to the leg.) ULP-F removed R6's condom catheter and took the urine collection bag to the bathroom and emptied the collection bag into the toilet. ULP-F sprayed a prepared cleaning solution into the collection bag to rinse the bag. ULP-F emptied the collection bag into the toilet. ULP-F removed gloves. The surveyor did not observe ULP-F perform hand hygiene. ULP-F hung the collection bag in the shower. ULP-F went to R6 who was lying in bed and removed one alarm attached to the left sleeve of R6's t-shirt and one alarm attached to R6's left sock. ULP-F applied a transfer belt around R6's waist and put shoes on R6's feet. On May 6, 2025, at 7:33 a.m., ULP-F walked R6 to the bathroom. ULP-F lowered R6's brief and asked R6 to sit on the toilet. ULP-F applied gloves. The surveyor did not observe ULP-F perform hand hygiene prior to glove application. ULP-F removed the brief that had been lowered and was at R6's feet. ULP-F got a pull up type of brief readied and a pair of pajamas for R6 to wear. ULP-F commented it was R6's shower day, and R6 would be dressed in pajamas at this time.	0 510		

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0 510	Continued From page 9 On May 6, 2025, at 7:37 a.m., ULP-F handed R6 a toothbrush. ULP-F warmed a washcloth under running water. ULP-F asked R6 if R6 wanted to spit (toothpaste). ULP-F handed R6 a glass that contained water and held an emesis basin while R6 rinsed mouth and spit into basin. On May 6, 2025, at 7:43 a.m., ULP-F wiped R6's bottom, and pulled up R6's brief and pajama bottoms. ULP-F removed gloves. On May 6, 2025, at 7:47 a.m., the surveyor observed ULP-F wash hands. On May 6, 2025, at 7:48 a.m., ULP-F stated she forgot to wash her hands in between glove changing. ULP-F stated she normally had hand sanitizer in her (ULP-F's) pocket, but her hands were dry and the sanitizer "burns." ULP-E ULP-E was hired on April 29, 2025, to provide direct care services to the facility's residents. ULP-E's employee record indicated ULP-E had received competency training to include infection control on April 29, 2025. On May 6, 2025, at 7:56 a.m., the surveyor observed ULP-E prepare R3's oral medication to include Systane wipes (eye/eye lid cleaner) and a bottle of brimonidine eye solution (high eye pressure). ULP-E got a pair of gloves and went to the dining room table where R3 sat. ULP-E handed R3 the Systane eye wipe. R3 wiped both eyes while seated at the table. ULP-E asked R3 to "look up." ULP-E placed one drop of eye solution into R3's right eye. ULP-E stated, "that was not very good" (eye drop administration).	0 510		

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0 510	Continued From page 10 ULP-E asked R3 if the drop "came out." ULP-E instilled another brimonidine eye drop into R3's right eye. ULP-E removed gloves. ULP-E asked R3 if R3 would like some water. ULP-E went into the kitchen, got a glass and filled it with water. ULP-E did not perform hand hygiene after eye medication administration and glove removal. On May 6, 2025, at 8:43 a.m., ULP-E stated she normally "came back" and used hand sanitizer after eye medication administration but she "missed it" (hand hygiene). On May 6, 2025, at 10:14 a.m., clinical nurse supervisor (CNS)-C stated ULPs were supposed to be washing their hands after glove removal. CNS-C stated it was best practice (to perform hand hygiene after glove removal). The licensee's Infection Control policy dated January 20, 2023, noted the licensee's infection control program would be consistent with current guidelines form CDC (center for disease control) for prevention control in long-term care facilities, where applicable in assisted living facilities. The licensee's Gloves policy dated July 27, 2022, noted gloves must be worn wherever there may be direct contact between any employee and contaminated objects or as instructed. Procedure: - wash hands - apply gloves to both hands - removed contaminated materials - place material in proper receptacle - remove gloves by grasping cuff of one clove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remanding glove and pull off, turning inside out - dispose used gloves in proper receptacle - rewashed hands.	0 510		

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0 510	Continued From page 11 The licensee's Mouth Care policy dated July 20, 2022, noted gather needed equipment, and explain procedure and provide privacy to resident - wash hands and apply gloves - encourage resident to do self-care, as much as possible - moisten toothbrush and /or toothettes - apply toothpaste to brush - brush resident's teeth using gentle, circular motion to all surfaces of teething, including gums, tongue, under tongue and roof of mouth - offer resident water to rinse - hold basin to allow resident to rinse and spit or have resident spit into bathroom sink - offer towel to wipe mouth, if needed - remove gloves and wash hands. The licensee's Catheter Care policy dated July 14, 2022, noted: - wash hands and apply gloves - hold catheter to prevent pulling - wash genital area from front to back, rinsing frequently - dry skin surface - removed gloves and wash hands. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=C	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:	0 640		

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0 640	Continued From page 12 (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 content in common areas, including posting the 911 emergency number in common areas on the main floor of the facility. This had the potential to affect 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 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 May 5, 2025, at approximately 10:10 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-C and licensed practical nurse (LPN)-B, the surveyor did not observe the required posting of 911 emergency number. On May 5, 2025, at 10:12 a.m., LPN-B pointed out, to the surveyor, a sign that laid on a side table in the common's area that noted: - if you need Emergency services there is a	0 640		

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0 640	Continued From page 13 phone located in the pantry (through the kitchen) to the left of entryway. Follow instructions located by phone. LPN-B then took the surveyor to the location of the pantry. The door was open, and LPN-B stated the door was open during the day but closed at night. The door had signage that noted: - Private Authorized Personnel Only! - Notice Employees only beyond this point. LPN-B pointed to a sign on the wall, in the pantry, that noted to dial 8-911 for emergency. Near the sign that noted dial 8-911 was a cordless phone. LPN-B stated residents could come back to the room to use the phone or the cordless phone could be taken to a resident's room. The cordless phone did not have the 911 emergency number posted. Directly after the above observation LPN-B stated she misunderstood the 911 requirement and "thought it was ok, to have a sign that noted where the emergency phone could be located. CNS-C stated residents could go back "there" (to pantry area) but added residents may not go to that location (pantry) to use the phone. LPN-B confirmed the 911 emergency number was not posted in the common's area as required. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated July 13, 2022, noted, the (name of licensee) would post information for reporting suspected crime and maltreatment. The facility would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: - posting the 911 emergency number in common areas and near telephones provided by the assisted living facility.	0 640		

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0 640	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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 have a written	0 680		

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0 680	Continued From page 15 emergency preparedness plan (EPP) posted in a prominent area and developed 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 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: POSTED IN PROMINENT AREA On May 5, 2025, at 10:07 a.m., during the entrance conference licensed assisted living director (LALD)-A stated the facility's EPP was located in the locked medication room (pantry area off the kitchen). On May 5, 2025, at 10:14 a.m., the surveyor observed a sign posted on the wall inside the facility that noted: - Attention: (name of licensee) has and maintains an emergency operations manual- it is available for you to review at any time upon your request! On May 5, 2025, at approximately 10:15 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-C and licensed practical nurse (LPN)-B the surveyor observed a door off the kitchen (pantry) that had signage that noted: - Private Authorized Personnel Only! - Notice Employees only beyond this point. On May 5, 2025, at 10:16 a.m., CNS-C stated the	0 680		

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0 680	Continued From page 16 facility's EPP was not posted prominently. CONTENT On May 5, 2025, at 1:22 p.m., the surveyor reviewed the facility's EPP with LALD-A. The facility's EPP contained: - a non-dated risk assessment - a Memorandums of Understanding form dated September 15, 2022, that noted transportation would be provided by (name of organization) - evacuation site (name of facility) agreement dated September 19, 2022 - evacuation site (name of facility) agreement dated September 20, 2022. During the review of the facility's EPP, LALD-A stated she "knew" she had reviewed the facility's EPP recently, but there was no documentation in the EPP of the recent review. LALD-A stated she would look elsewhere "to see" if she (LALD-A) could locate when she had reviewed the facility's EPP. LALD-A stated the transportation and evacuation site contracts had not been renewed as required. LALD-A stated she knew that one of the relocation sites had changed hands (ownership) recently. On May 5, 2025, at 1:23 p.m., LALD-A stated "I know" we (facility staff) "just talked" about the missing resident plan last fall. LALD-A stated the missing person plan was reviewed every six months. LALD-A later stated it was possible the licensee reviewed the missing person plan during quality management (QM) meetings. LALD-A reviewed QM meeting minutes and stated the licensee had not been reviewing missing person policy quarterly as required. On May 7, 2025, at 9:10 a.m., LALD-A stated she	0 680		

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0 680	Continued From page 17 could not find any documentation of the review of the facility's EPP. LALD-A stated she would "have to get better at that (annual review of EPP). LALD-A confirmed the facility's EPP had not been fully reviewed as required. This licensee's Policies & Procedures Overview dated September 15, 2022, noted (name of licensee) shall maintain an Emergency Plan describing our all-hazards approach to emergency management. The Emergency Plan and guidelines would be developed and made widely available to all staff. This plan will be maintained in accordance to state and federal guidelines and will be reviewed and updated annually. The licensee's Missing Resident policy dated August 3, 2022, noted (name of licensee) would review policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented. The licensee's Risk Assessment-All Hazards policy dated September 15, 2022, noted the Hazard Vulnerability Assessment was reviewed at least annually. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under	0 680		

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0 680	Continued From page 18 Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 775		

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0 775	Continued From page 19 On a facility tour on May 6, 2025, from 10:00 a.m. to 11:30 a.m., with maintenance (M)-H, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXPOSED FOAM PLASTIC INSULATION It was observed that foam plastic insulation, Insulated Concrete Forms (ICF) was exposed with no thermal barrier (1/2-inch-thick drywall minimum) in the basement. There was no documentation from the manufacturer available indicating the ICF's do not require a thermal barrier. It was explained that a thermal barrier is required to be installed to protect the surface of the foam plastic from ignition in the event of a fire by MSFC in Minnesota Rules Chapter 7511. During the facility tour M-H, and licensed assisted living director (LALD)-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	0 780		

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0 780	Continued From page 20 (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 dwelling unit. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 6, 2025, from 10:00 a.m.	0 780		

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0 780	Continued From page 21 to 11:30 a.m., with maintenance (M)-H, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms within the dwelling unit. During the tour M-H, activated the test button on all smoke alarms within the dwelling unit including the basement alarm. Each smoke alarm sounded independently of all others except the alarms inside resident sleeping rooms 101-1 and 101-2, and 201-1 and 201-2. The smoke alarms inside sleeping room 101 were interconnected and the smoke alarms inside sleeping room 201 were interconnected. 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 M-H, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 22 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, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 23 or has potential to affect a large portion or all of the residents). The findings include: On May 6, 2025, at 8:45 a.m., licensed assisted living director (LALD)-A, 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 dated August 15, 2022, failed to include the following: The available FSEP included standard employee policy, but failed to provide specific employee actions and procedures to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. 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 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. The individual resident unique needs for	0 810		

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0 810	Continued From page 24 evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on May 6, 2025, at 9:00 a.m., LALD-A, stated the FSEP employee and resident procedures in the event of a fire or similar emergency needed to be added to the FSEP and resident evacuation status/ unique needs for evacuation were not available within the facility for immediate reference. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the employees were trained upon hire and only thereafter only. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by providing documentation the residents were included in fire evacuation drills but not provided specific training base on their procedures in the FSEP. During an interview on May 6, 2025, at 9:30 a.m., LALD-A, stated documentation was not available indicating employees were trained twice per year as required and documentation was not available indicating residents were offered training as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct	0 810		

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0 810	Continued From page 25 evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed February 2024, April 2024, July 2024, September 2024, and December 2024. One drill was documented during the night shift the remainder of the drills were during day and afternoon shifts. During an interview on May 6, 2025, at 9:45 a.m., stated documentation was not available indicating fire evacuation drills were competed every other month and twice per shift per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under 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:	01290		

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01290	Continued From page 26 Based on observation, interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 30400) for one of eight employees, (director of maintenance/DM-H). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 5, 2025, at approximately 9:20 a.m., during the entrance conference the surveyor requested background study verification for all current facility employees (NETStudy results). Licensed assisted living director (LALD)-A had previously provided the surveyor an employee list (employee contact list) that included employee name, title, hire date, and phone number. DM-H was listed on the employee list, title: maintenance. DM-H was not listed on the NETStudy result list. DM-H was hired on January 1, 2019. DM-H's employee record included a background study dated July 20, 2021, for HFID 23735. DM-H's employee record lacked documentation of a cleared background study for HFID 30400.	01290		

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01290	Continued From page 27 On May 6, 2025, from approximately 10:00 a.m. to 11:30 a.m., the surveyor observed DM-H tour the engineer surveyor around the facility and answer the engineer surveyor's questions. On May 7, 2025, at 11:35 a.m., LALD-A stated DM-H was at the facility on Wednesday, "grocery day" and as needed. LALD-A stated she was not aware DM-H's background study needed to be affiliated with the assisted living license. LALD-A added she "thought of" DM-H as being a contracted employee. The licensee's Background Studies policy dated August 4, 2022, noted the licensee would conduct a Minnesota Department of Human Services Background study on all employees and volunteers and contractors at the facility. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	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	01420		

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01420	Continued From page 28 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 demonstration was completed for one of one unlicensed personnel (ULP-E). Additionally, the licensee failed to provide written instructions in the resident records for delegated tasks for two of three residents (R6, 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: During the entrance conference on May 5, 2025, at 9:35 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-C, and licensed practical nurse (LPN)-B stated the licensee provided treatment and therapy services to residents at the facility such as use of Hoyer (mechanical lift), modified diets, wound care, assist with ADLs (activities of daily living-mobility,	01420		

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01420	Continued From page 29 dressing, bathing, eating, etc.), and provided chronic illness management. TRAINING AND COMPETENCY ULP-E was hired on April 29, 2025, to provide direct care services to the facility's residents. On May 5, 2025, at approximately 2:30 p.m., the surveyor observed ULP-E push R5 in a tilt-n-space wheelchair (a wheelchair which has a seat that tilts backward while keeping the user's hips, knees, and ankles at 90 degrees) to R5's room and administer furosemide (fluid retention) 40 milligrams (mg) to R5. On May 5, 2025, at 3:08 p.m., the surveyor observed ULP-F place her hands on the handles on the back of R5's tilt-n-space wheelchair and reposition the tilt of R5's wheelchair. ULP-E and ULP-F then transferred R5 out of the tilt-n-space wheelchair with aid of a Hoyer into a hospital bed. ULP-E's training record did not include: - tilt-n-space wheelchair - warm/cold packs. On May 6, 2025, at 10:26 a.m., CNS-C stated there were two tilt-n-space wheelchairs used at the facility (R5, R10). CNS-C stated R10's tilt-n-space was put into place by PT/OT (physical therapy/occupational therapy). CNS-C stated PT/OT may have spoken to ULPs about the tilt-n-space wheelchair at the time R10 received the wheelchair. CNS-C stated she did not "think" about training and deeming ULPs competent on tilt-n-space wheelchairs. CNS-C confirmed she had not trained or deemed any of the ULPs competent on tilt-n-space wheelchairs used at the facility.	01420		

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01420	Continued From page 30 On May 7, 2025, at 9:31 a.m., CNS-C stated she completed no training or competencies for warm/cold packs. CNS-C stated the licensee had a binder labeled, Procedure Book, that ULPs were to review, which included warm packs and ice packs. CNS-C stated she did not train or deem ULPs competent on warm/cold packs. CNS-C confirmed a resident record (R6) included warm pack/ ice pack application. INSTRUCTIONS IN RECORD TILT-N-SPACE WHEELCHAIR R5 R5's diagnosis included atherosclerotic heart disease (hardening and narrowing of the arteries/ reducing blood flow), atrial fibrillation (irregular and often rapid heart rhythm), hemiplegia and hemiparesis (one sided paralysis or weakness) following cerebral infraction (ischemic stroke/blood flow to the brain disrupted) and chronic kidney disease stage three (moderate decrease in kidney function). R5's service plan dated April 25, 2025, included: -mobility: use of wheelchair, mobility: assist of one with manual wheelchair. R5's comprehensive assessment dated April 30, 2025, included: -mobility and transfer needs: -dependent -wheelchair. R5's record did not include specific instructions for tilt-n-space wheelchair use. On May 6, 2025, at 10:23 a.m., R5's record was reviewed with CNS-C. CNS-C stated R5's record did not include instructions for the use of tilt-n-space wheelchair, to include when to have	01420		

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01420	Continued From page 31 the wheelchair tilted or not to have the wheelchair tilted. WARM/COLD PACKS R6 R6 diagnosis included legal blindness, vascular dementia, anxiety, depression, and urge incontinence. R6's service plan dated July 18, 2023, included monitor pain. On May 6, 2025, at 7:28 a.m., the surveyor observed ULP-F remove a condom catheter (external urinary catheter, worn like a condom over the penis which collected urine as it drains out of the bladder and sends the urine into a collection bag strapped to the leg) for R6. ULP-F stated, "bear with me Buddy (R6). I feel bad, it hurts." R6's May 1, 2025, through May 5, 2025, medication administration record (MAR) included: -warm/cold packs as needed (PRN) for comfort per nursing discretion. On May 7, 2025, at 9:31 a.m., CNS-C stated ULPs could refer to the Procedure binder located in the "pantry" for instructions/direction for warm/ice pack use. CNS-C confirmed R6's record did not include instructions for use. CNS-C commented she was not sure what ULPs would use for a "hot pack". CNS-C stated warm/ice pack application was a nursing intervention for comfort. Undated instructions for warm/ ice packs found in "Procedure Book" located on a shelve in the medication area/pantry noted: Warm Pack: to warm the hot pack: step 1-3 step	01420		

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01420	Continued From page 32 4-5 placing hot pack on resident/storage 1. place pack in plastic bag and put in microwave. Do not seal bag 2. set time for one-minute, flip pack, set time for another 30 seconds 3. place warm pack on your arm to check temperature 4. pace over clothing for 20 minutes then removed. ** Do not expose bare skin** 5. leave plastic bag in cupboard over the microwave. Ice Pack Application -application of a cold or ice placed in a plastic bag and wrapped in a towel or other protective barrier, to protect the skin from ice burn -ice pack should not be applied longer than 20 minutes at a time. The licensee's Delegation of Assisted Living Services policy dated September 15, 2022, noted a RN or licensed health professional at the facility may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to eh appropriate Minnesota practice act. When the RN delegated tasks to ULPs, that person would ensure that prior to the delegation the ULP was trained in the proper methods to perform the tasks or procedures for each resident and was able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the RN or licensed health professional would document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		

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01640	Continued From page 33	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three residents (R3) service plan was revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640		

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01640	Continued From page 34 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included polymyalgia rheumatica (inflammatory disorder) and hypertension (HTN/high blood pressure). R3's Service Plan dated September 26, 2024, included: -monitoring weight, weekly. R3's treatment management form dated February 13, 2025, included: -weight per doctor orders -notify nurse if there is weight gain of three pounds in one day, or five pounds in one week. R3's treatment plan dated February 21, 2025, included: -weight monitoring. R3's electronic medication administration record (EMAR) dated May 1, 2025, through May 6, 2025, included: -daily weight one time a day for edema. R3's record included daily weight summary dated April 18, 2025, through May 7, 2025 - out of 20 opportunities, R3's weight was monitored 23 times - weight ranged from 150.6 pounds to 154.8 pounds. R3's prescriber order dated November 20, 2024, included daily weights, appointment in two weeks. On May 6, 2025, at 7:49 a.m., the surveyor	01640		

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01640	Continued From page 35 observed unlicensed personnel (ULP)-E ask R3 to stand on the scale in the dining area to obtain a weight of 154 pounds. On May 7, 2025, at 9:19 a.m., the surveyor reviewed R3's record with clinical nurse supervisor (CNS)-C and licensed practical nurse (LPN)-B. LPN-B stated R3's prescriber had ordered daily weights which was to be reviewed in two weeks. LPN-B stated when R3 was next seen by a nurse practitioner (NP) daily weights were continued. CNS-C stated R3's service plan had not been updated as required. The licensee's Service Plan Modification policy dated July 13, 2022, noted if the service plan needed to be modified due to a change in a prescriber's order or a change in the resident's needs, the service plan modification form would be completed: this form included: - describe changes in service and whether the service is added (new), changed, or discontinued - frequency of new service or if service terminated - identification of the staff who would perform the service - schedule and methods of monitoring staff - fee for the service - date/signature of RN (registered nurse) making changes - date/signature of resident or the resident's representative each time a modification was made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01700	Continued From page 36	01700		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to assess residents for ability to self-administer after set up for scheduled medications for two of four residents (R3, R8). This practice resulted in a level two violation (a	01700		

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01700	Continued From page 37 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: R3 R3's diagnoses included polymyalgia rheumatica (inflammatory disorder) and hypertension (HTN/high blood pressure). R3's Service Plan dated September 26, 2024, included: - client (resident) will receive all medications as ordered by authorized prescriber and will be listed in the EMAR (electronic medication administration record). R3's Medication Administration Assessment dated June 7, 2024, included: - the resident can correctly read label and/or identify each medication: requires assistance - the resident can correctly state what each medication is for: requires assistance - the resident can correctly state the time/frequency medications are to be taken: requires assistance - the resident can open medication packages/containers requires assistance - the resident can appropriately document self-administration of the medication s listed: requires assistance - the resident can demonstrate secure storage of medication kept in room: requires assistant	01700		

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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
01700	Continued From page 38 - can state the appropriate situations for self-administration of PRN (as desired or as needed) medication: requires assistance - resident safe to self-administer listed medications? no - medication management needs: medication administration by staff. R8 R8's diagnoses included osteoporosis, HTN, kidney disease, and congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R8's Service Plan dated September 26, 2024, included: - client will receive all medications as ordered by authorized prescriber and will be listed in the EMAR. R8's Medication Administration Assessment dated August 21, 2024, included: - the resident can correctly read label and/or identify each medication requires assistance - the resident can correctly state what each medication is for: requires assistance - the resident can correctly state the time/frequency medications are to be taken: requires assistance - the resident can open medication packages/containers requires assistance - the resident can appropriately document self-administration of the medication s listed: requires assistance - the resident can demonstrate secure storage of medication kept in room: requires assistant - can state the appropriate situations for self-administration of PRN (as desired or as needed) medications: completely capable - resident safe to self-administer listed	01700		

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	30400	A. BUILDING: _____ B. WING _____	05/07/2025

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01700	Continued From page 39 medications? yes (PRN) - medication management needs: resident partially able to self-administer medication, medication administration by staff. On May 6, 2025, at 7:56 a.m., the surveyor observed ULP-E prepare R3's morning medication. ULP-E placed a cup of medication in front of R3 and walked into the kitchen. On May 6, 2025, at 8:06 a.m., the surveyor observed ULP-E ask R3 if she could return the cup of medication to the medication room. R3 replied, no. ULP-E left the prepared medication with R3 and returned to the kitchen area. On May 6, 2025, at 8:07 a.m., the surveyor observed R8 seated at the dining room table with three other residents (R3, R7, R9). ULP-E went to the medication room located off the kitchen (pantry area) and prepared R8's medication. ULP-E placed a cup of oral medications and the glass of orange which contained Benefiber (bowel health) near R8. ULP-E prepared R8's requested breakfast (dark toast with peanut butter and jelly, and fruit). On May 6, 2025, at 8:16 a.m., ULP-E noticed R8's medication cup with the medication un-taken. On May 6, 2025, at 8:17 a.m., ULP-E asked R9 what R9 would like for breakfast. ULP-E prepared R9's breakfast of choice. On May 6, 2025, at approximately 8:35 a.m., R8 took the oral medication placed near her. On May 6, 2025, at 8:30 a.m., the surveyor observed ULP-E place a medication cup in front	01700		

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01700	Continued From page 40 R9. On May 6, 2025, at 10:07 a.m., the surveyor reviewed the observation of medication administration for R3, R8, R9 with clinical nurse supervisor (CNS)-C. CNS-C reviewed R8 and R3's medication assessments and stated their (R8, R3) current medication assessments noted that medications were to be administrated by ULPs. CNS-C stated R3, R8, and R9 were "independent", and their (R3, R8, R9) medication assessments should have been updated to note medications could be left with them after set up. The licensee's undated Initial Individualized Medication Management Plan policy noted medication management plan would be reviewed periodically and modified as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for three of three residents (R3, R6, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 R3's diagnoses included polymyalgia rheumatica (inflammatory disorder) and glaucoma (high eye pressure). R3's Service Plan dated September 26, 2024, included: - medication management, client (resident) will receive all medication as ordered by authorized prescriber and will be listed in the EMAR (electronic medication administration record). R3's EMAR dated May 1, 2025, through May 5, 2025, included: - brimonidine ophthalmic solution 0.2 % (glaucoma). Instill one drop in right eye two times a day, 8:00 a.m., 8:00 p.m. - Systane ophthalmic solution 0.4-0.3 %) instill one drop in both eyes every six hours as needed	01750		

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01750	Continued From page 42 (PRN) for dry eyes (ok'd by RN (registered nurse) to give in afternoon and nightly as requested). R3's prescriber's order dated November 20, 2024, included the above orders. R3's May EMAR included: - May 3, 2025, PRN Systane solution administered at 1916 (7:16 p.m.) - May 4, 2025, PRN Systane solution administered at 1921 (7:21 p.m.). On May 6, 2025, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's medication to include a bottle of brimonidine eye solution. ULP-E placed one drop of eye solution into R3's right eye. ULP-E stated, "that was not very good" (eye drop administration). ULP-E asked R3 if the drop "came out." ULP-E instilled another brimonidine tartrate into R3's right eye. R3's record did not include specific resident instructions relating to the administration of eye medication, to include wait time between eye drop medication. On May 6, 2025, at approximately 11:00 a.m., the surveyor reviewed R3's EMAR with clinical nurse supervisor (CNS)-C and manufacturer's instructions for eye drops. CNS-C stated R3's record did not include specific resident instructions for eye drop administration. The manufacturer's instructions for brimonidine dated November 15, 2023, noted if you are to use more than one drop in the same eye, wait at least five minutes before instilling the next drop. The manufacturer's instructions for Genteal	01750		

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01750	Continued From page 43 (Systane) eye drops dated March 20, 2025, noted wait for at least five to ten minutes before delivering any other medication int the same eye to avoid dilution. R6 R6's diagnoses included diabetes, legal blindness, vascular dementia, anxiety, kidney stone, and urge incontinence. R6's service plan dated July 18, 2023, included: - medication management, client will receive all medication as ordered by authorized prescriber and will be listed in the EMAR. R6's May 1, 2025, through May 5, 2025, EMAR included: - Benefiber oral powder (wheat dextrin) give two teaspoons by mouth one time a day for constipation. Hold for loose stools. R6's prescriber order dated September 6, 2023, included: Benefiber one scoop daily. Hold for loose stools; wife will provide. On May 6, 2025, at 7:14 a.m., the surveyor observed ULP-E take R6's blood glucose reading using correct technique ULP-E documented a reading of 103 in R6's EMAR. R6's record lacked to include specific resident instructions relating to the administration of Benefiber. On May 7, 2025, at 9:23 a.m., the surveyor reviewed R6's record with CNS-C. CNS- C stated R6's record did not include complete instructions for Benefiber. CNS-C confirmed R6's Benefiber lacked directions to mix with a type of liquid and how much liquid to add.	01750		

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01750	Continued From page 44 The manufacturer's instructions Benefiber dated 2023, noted for ages 12 and above, stir two teaspoons of Benefiber Original into four to eight ounces of beverage or soft food (hot or cold), Stir well until dissolved (up to 60 seconds). Not recommended for carbonated beverages. R8 R8's diagnoses included osteoporosis, hypertension (HTN- high blood pressure), kidney disease, and congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R8's Service Plan dated September 26, 2024, included: - client will receive all medications as ordered by authorized prescriber and will be listed in the EMAR. R8's May 1, 2025, through May 5, 2025, EMAR included: - alendronate sodium 70 milligrams (mg), give one tablet by mouth one time a day every Thursday, related to age-related osteoporosis (in its own medication box). On May 6, 2025, at 7:56 a.m., the surveyor observed ULP-E prepare R8's morning medication. ULP-E placed a cup of medication in front of R8 and walked into the kitchen. R8's record lacked to include specific resident instructions relating to the administration of alendronate sodium. On May 6, 2025, at 12:24 p.m., the surveyor reviewed R8's record with CNS-C and the manufacturer's instruction for Fosamax	01750		

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01750	Continued From page 45 (alendronate sodium). CNS-C stated R8's record did not include specific resident instructions as required. The manufacturer's instructions for Fosamax dated 2000, noted after getting up for the day and before taking your first food, drink, or other medicine, swallow Fosamax tablet with a full glass (six to eight ounces) of plan water only (not mineral water, not coffee or tea, not juice). Do not chew or suck on tablet of Fosamax. After swallowing tablet, do not lie down, stay fully upright (sitting, standing, or waling) for at least 30 minutes. Do not lie down until after your first food of the day. after swallowing Fosamax, wait at least 30 minutes before taking your first food, drink, or other medicine the day. The licensee's Medication & Treatment-Administration & Delegation policy dated August 30, 2021, noted when administration of medications was delegated or assigned to unlicensed personnel, the licensee would ensure that the RN had: - specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	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	01760		

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01760	Continued From page 46 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of three residents (R6) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 diagnosis included legal blindness, vascular dementia, anxiety, depression, kidney stone, and urge incontinence. R6's service plan dated July 18, 2023, included: - medication management, client will receive all medication as ordered by authorized prescriber and will be listed in the EMAR (electronic	01760		

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01760	Continued From page 47 medication administration record). R6's May 1, 2025, through May 5, 2025, EMAR included: - Crystal Light lemon-powder packets (16 ounces of water) three times a day for per urology recommendation, kidney stones, give at mealtimes! (8:00 a.m., 12:00 p.m., 5:00 p.m.) R6's prescriber order dated February 4, 2025, included: - Crystal Light lemon three times a day and more often if tolerated. Scheduled at 8:00 a.m., 12:00 p.m., 5:00 p.m., and PRN (as desired or as needed). On May 7, 2025, at 10:00 a.m., R6's record was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R6's EMAR did not include a PRN entry for R6's Crystal Light lemon drink as ordered. CNS-C stated licensed practical nurse (LPN)-B would add PRN Crystal Light lemon drink to R6's EMAR. On May 7, 2025, at approximately 10:15 a.m., LPN-B stated she missed the PRN order for R6's Crystal Light lemon drink but "it is there now" LPN-B stated. The licensee's Medication & Treatment Orders-Implementing policy dated January 6, 2023, noted upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 48 days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel with topical medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 5, 2025, at 9:47 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated medications were kept in a room off the kitchen. CNS-C stated medications were secured, in a locked cabinet. CNS-C stated the "medication room" (pantry area) contained all medication and there was a computer "right there" for documentation. CNS-C stated residents were not able to keep (store) medication in their rooms without a prescriber's order.	01880		

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01880	Continued From page 49 On May 5, 2025, at 10:12 a.m., during a tour of the facility licensed practical nurse (LPN)-B stated residents could come into the pantry area (medication area) to use the telephone. On May 5, 2025, at approximately 10:15 a.m., during a tour of the facility with CNS-C and LPN-B the surveyor observed an open door off the kitchen (pantry) that had signage that noted: - Private Authorized Personnel Only! - Notice Employees only beyond this point. On May 5, 2025, at 2:30 p.m., the surveyor observed an un-lidded, unsecured cardboard box located in the area used for medication preparation which was off the kitchen (pantry) area. In the box was an opened diclofenac sodium topical gel (pain relief) 1% for R2. CNS-C observed and confirmed R2's topical medication was located in the unsecured box and stated R2's topical medication should have been secured. CNS-C stated the pantry door (medication area) was locked at night. CNS-C stated she "never" thought about the topical medications not being secured. On May 5, 2025, at 3:08 p.m., LPN-B stated she was "trying something else". LPN-B stated she put all creams and "TAR" (treatment administration record) items in that box. LPN-B stated the topical medications were getting missed (not administered). LPN-B stated right now only one resident had a topical medication, however in the past there had been several residents that used topical medication. LPN-B stated yes, all medication, including topical medication should be secured. On May 6, 2025, at 6:11 a.m., the surveyor observed the door to the panty (medication	01880		

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01880	Continued From page 50 preparation and storage area) open. Unlicensed personnel (ULP)-D stated the door was kept open all the time. The licensee's Storage of Medications policy dated July 13, 2022, noted medications would be kept securely locked. In addition, medications managed by the (name of licensee) would be stored to prevent diversion of medications by residents or others who may have access to the medication Diversion means the misuse, theft, or illegal or improper dispositions of medications. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 medication was maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications, in one of one medication storage area.	01890		

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01890	Continued From page 51 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: TIME SENSITIVE MEDICATION On May 5, 2025, at 10:21 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C and licensed practical nurse (LPN)-B, to include a locked medication closet. CNS-C observed and confirmed the following: - opened brimonidine 2% eye solution (glaucoma/high eye pressure) for R4, undated (lacked open/expiration date) - opened brimonidine 2% eye solution for R3, dated "March 25" (lacked complete open date and lacked expiration date) - opened Genteal eye solution (dry eyes) for R2, dated April 1 (lacked complete open date and lacked expiration date. LEGIBLE INFORMATION - opened brimonidine 2%, LPN-B stated she knew the medication was for R3. LPN-B stated the label "rubbed" off only "3/25" written in black magic marker was legible. LPN-B stated a replacement label should have been applied to R3's brimonidine eye solution. On May 5, 2025, at 11:11 a.m., LPN-B stated opened time sensitive medications should include an open date and an expiration date. LPN-B stated staff were supposed to be using labels	01890		

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	30400	A. BUILDING: _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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
01890	Continued From page 52 (with open and expiration date). On May 5, 2025, at 11:25 a.m., the surveyor reviewed the medication storage with CNS-C. CNS-C stated dating time sensitive medication was a widespread issue. The manufacturer's instructions brimonidine eye solution dated December 7, 2021, noted eye drops can be used for four weeks once the bottle had been opened. Even if there is still some solution remaining after this time, throw it. The manufacturer's instructions for Genteal eye drops dated March 20, 2025, noted make sure to use within four weeks of opening the bottle. The licensee's Medication Storage policy dated July 13, 2022, noted, when medication was managed and stored by the (name of licensee) medications will be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 53 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R6) receiving treatments. 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: R6 diagnosis included legal blindness, vascular dementia, anxiety, depression, and urge incontinence. On May 6, 2025, at 7:28 a.m., the surveyor observed R6 lying in bed, wearing a condom catheter (external urinary catheter, worn like a condom over the penis which collects urine as it	01950		

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01950	Continued From page 54 drains out of the bladder and sends the urine into a collection bag strapped to the leg.) Unlicensed personnel (ULP)-F removed R6's condom catheter and took the urine collection bag to the bathroom and emptied the collection bag into the toilet. ULP-F sprayed a prepared cleaning solution into the collection bag to rinse the bag. ULP-F emptied the collection bag into the toilet. ULP-F hung the collection bag in the shower. R6's service plan dated July 18, 2023, included: - condom catheter at night - medications as ordered by authorized prescriber and listed on the EMAR. R6's treatment plan dated March 18, 2024, initiated July 17, 2023, noted: condom catheter - applied at HS (hour of sleep) and off at a.m. (morning), cares. Empty bag, wash with three parts water/one part vinegar solution, and reused. Sheath for around penis to keep in place, is to be kept and reuse if able - checking at NOC (night) shift to be sure its secure and functioning. R6's May 1, 2025, through May 5, 2025, EMAR included: - condom catheter, on at HS, off at a.m., every morning and at bedtime related to urge incontinence. R6's record included prescriber order dated January 31, 2025, included the above orders. On May 6, 2025, at 11:30 a.m., the surveyor reviewed R6's record with CNS-C. CNS-C stated R6's record did not include what or when to report issues to nursing for condom catheter. The licensee's Delegation of Assisted Living	01950		

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01950	Continued From page 55 Services policy dated September 15, 2022, noted a RN or licensed health professional at the facility may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to eh appropriate Minnesota practice act. When the RN delegated tasks to ULPs, that person would ensure that prior to the delegation the ULP was trained in the proper methods to perform the tasks or procedures for each resident and was able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the RN or licensed health professional would document instructions for the delegated tasks in the resident's record. The licensee's Treatment and Therapy Management Plan policy dated January 6, 2023, noted when administration of a treatment or therapy was delegated or assigned to ULP, the facility would ensure that the RN or authorized licensed health professional had: - documentation of specific resident instructions relating to the treatments or therapy administration - any resident-specific requirements relating to documentation of treatment and therapy received - procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 56 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards by one of one unlicensed personnel (ULP-E) during medication administration for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 6, 2025, at 8:07 am, the surveyor observed R8 seated at the dining room table with three other residents (R3, R7, R9). ULP-E asked R8 what she would like for breakfast. ULP-E went to the medication room located off the kitchen (pantry area) and prepared R8's medication, to include Benefiber powder (bowel health). ULP-E mixed the Benefiber into a glass of orange juice. ULP-E placed a cup of oral medications and the glass of orange juice which contained Benefiber near R8. ULP-E prepared R8's requested	02320		

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02320	Continued From page 57 breakfast. On May 6, 2025, at 8:16 a.m., ULP-E noticed R8's medication cup with the medication un-taken. ULP-E commented she (ULP-E) could not document R8's medication as administered until R8 took the medication. On May 6, 2025, at 8:18 a.m., the surveyor observed that R8 had not yet drank any of the Benefiber mixed in orange juice. On May 6, 2025, at approximately 8:35 a.m., R8 took the oral medication placed near her. R8 had not yet drank any of the Benefiber mixed in orange juice. On May 6, 2025, at approximately 8:40 a.m., ULP-E documented R8's medication as administered, to include Benefiber. On May 6, 2025, at 8:42 a.m., ULP-E stated she had documented R8's Benefiber as administered, prior to R8 drinking any of the Benefiber mixed with orange juice. ULP-E stated she should not have documented R8's Benefiber as administered prior to R8 drinking the mixture. ULP-E stated "it" (R8 drinking the medication/orange juice mixture) normally did not take that long. On May 6, 2025, at 10:02 a.m., clinical nurse supervisor (CNS)-C stated ULP-E should not have documented R8's Benefiber as administered before R8 drank the medication mixture. CNS-C stated ULP-E just returned to work at the facility so ULP-E was "new again and would need to relearn." The licensee's Medication & Treatment Record-	02320		

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02320	Continued From page 58 Documentation & Refusal policy dated July 13, 2022, noted the following must be document in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: - the date - the time - the quantity of dosage - the method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy - documentation in the MAR of the authorized person who provided the assistance and/or administration of medications/treatment/therapy Documentation of medication/treatment/therapy administration would be completed by the person who performed the task immediately after the medication assistance/administration was completed. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy	02410		

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02410	Continued From page 59 (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for one of three residents (R3) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	02410		

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02410	Continued From page 60 situation has occurred only occasionally). The findings include: R3's diagnoses included polymyalgia rheumatica (inflammatory disorder) and glaucoma (high eye pressure). R3's Service Plan dated September 26, 2024, included: - medication management, client (resident) will receive all medication as ordered by authorized prescriber and will be listed in the EMAR (electronic medication administration record). R3's EMAR dated Mary 1, 2025, through May 5, 2025, included: - brimonidine ophthalmic solution 0.2 % (glaucoma). Instill one drop in right eye two times a day - Systane Lid Wipes external pad (eyelid cleansers) apply to both eyes topically two times a day. R3's prescriber's order dated November 20, 2024, included the above orders. On May 6, 2025, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's medication to include Systane wipes and a bottle of brimonidine eye solution. ULP-E got a pair of gloves and went to the dining room table where R3 sat with three other residents (R7, R8, R9) who were eating breakfast. ULP-E handed R3 the Systane eye wipe. R3 wiped both eyes while seated at the table. ULP-E asked R3 to "look up." ULP-E placed one drop of eye solution into R3's right eye. ULP-E stated, "that was not very good" (eye drop administration). ULP-E asked R3 if the drop "came out." ULP-E instilled	02410		

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02410	Continued From page 61 another brimonidine into R3's right eye. Two of the residents were observing R3. The surveyor did not observe ULP-E ask R3 about eye medication administration while at the table or offer R3 to leave the dining room table for eye medication administration. On May 6, 2025, at 8:43 a.m., ULP-E stated R3's eye drops were given at the table during breakfast. On May 6, 2025, at 9:59 a.m., clinical nurse supervisor (CNS)-C and licensed practical nurse (LPN)-B stated "they" (ULPs) know not to administer eye medication at the dining room table. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. In addition, residents have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/05/25*
Time: 12:09:58
Report: 7939251085

Food and Beverage Establishment Inspection Report

Location:
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0038262
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183265730
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW MEATS STORED OVER READY TO EAT ITEMS SUCH AS COLESLAW AND CARROTS

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: DUNK SINK
Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit
Location: RAG BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TURKEY AL A KING
Temperature: 181 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: PASTA
Temperature: 37 Degrees Fahrenheit - Location: LOWER LEVEL KITCHEN FRIDGE
Violation Issued: No

Type: Full
Date: *05/05/25*
Time: 12:09:58
Report: 7939251085
Sugar Brook Villa

Food and Beverage Establishment Inspection Report

Process/Item: STAWBERRY FLUF
Temperature: 38 Degrees Fahrenheit - Location: DRY STORAGE FRIDGE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	0

INSPECTED KITCHEN AND WALKED SEPTIC SYSTEM AND WELLHEAD

DISCUSSION
HANDLES UP IS STORED IN BULK FOODS SUCH AS SUGAR.
AIR DRYING UTENSILS BEFORE PUTTING AWAY.

PLEASE EMAIL ME A PICTURE OF THE WARE WASH MACHINE TEMPERATURE TEST STICKER FROM THE DISH WASHER.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251085 of 05/05/25.

Certified Food Protection Manager: KRISTILEE CHRISTENSEN

Certification Number: FM114062 Expires: 11/22/25

Signed: _____
COURTNEY SELGER
COOK

Signed: _____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us