Electronically Delivered

July 21, 2025

Licensee
Evensong Manor
6264 Yukon Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL30500017

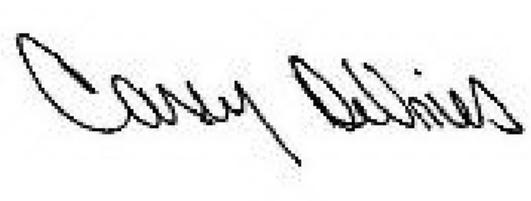
Dear Licensee:

On June 3, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 27, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

JMD

Electronically Delivered

April 22, 2025

Licensee
Evensong Manor
6264 Yukon Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL30500017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 27, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

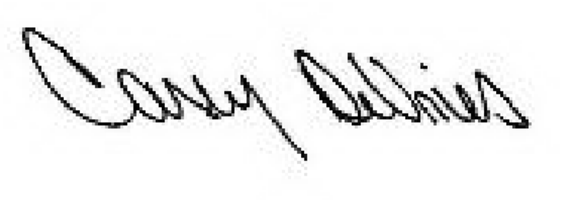
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	30500	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL30500017-0 On March 24, 2025, through March 27, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on March 25, 2025, issued for SL30500017-0, tag identification 1750. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily	0 345		

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0 345	Continued From page 1 accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey concluded on April 6, 2023. 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 the potential to affect a large portion or all the residents). The findings include: On March 25, 2025, at 3:40 p.m., the surveyor requested licensed assisted living director	0 345		

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0 345	Continued From page 2 (LALD)-D provide a copy of the facility's most recent plan of correction for the survey completed on September 7, 2023. LALD-D provided a survey state form with no corrections and stated they had not written any corrections. The licensee's survey completed on March 27, 2025, identified non-compliance in the following areas, which were also identified during the survey completed on September 7, 2023: 0470, 0480, 0660, 0680, 0730, 0780, 0790, 0800, 0810, 1460, 1620, 3090. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's	0 460		

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0 460	Continued From page 3 unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs twenty-four hours a day, seven days a week. 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 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 March 24, 2025, at 10:30 a.m., licensed assisted living director (LALD)-D stated the licensee's residents did not have a means to call for help from their rooms. LALD-D also stated the licensee's residents were ambulatory and were able to walk to staff or call for help if needed. On March 24, 2025, at 11:30 a.m., during a tour of the facility, the surveyor observed resident rooms and did not observe any means available for residents to summon staff. On March 24, 2025, at 11:45 a.m., LALD-D stated they had not gotten any type of system for residents to summon staff as they had the ability to find staff when they needed them. LALD-D also stated the residents had their cell phones and could call any staff member for help even in the	0 460		

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0 460	Continued From page 4 night. On March 25, 2025, at 10:30 a.m., the surveyor overheard R5 request to borrow unlicensed personnel (ULP)-C's cellphone so R5 could make a call to their mother. However, ULP-C declined the request stating they were leaving early. On March 25, 2025, at 10:35 a.m., the surveyor inquired from ULP-B if R5 had a cellphone, ULP-B stated they had not seen R5 with a phone. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly 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;	0 470		

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0 470	Continued From page 5 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. In addition, the licensee failed to post the 24-hour staffing schedule in a central location for residents and their families. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of five residents, and currently had four residents. On March 24, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living	0 470		

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0 470	Continued From page 6 director (LALD)-D stated they had a staffing plan but was unsure how often it was required to be updated. LALD-D also stated clinical nurse supervisor (CNS)-A had the staffing plan but was out on vacation. On March 24, 2025, at 11:30 a.m., during the facility tour, the surveyor observed in the common areas and noted the 24-hour daily staffing schedule was not posted for residents. On March 25, 2025, at 3:00 p.m., LALD-D stated the daily staffing schedule was posted but a resident had pulled down the board and they had yet to replace it. The licensee's Staffing and Scheduling policy dated August 1, 2024, indicated clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The policy also indicated clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and - the direct-care staff member's resident assignments or work location. In addition, the policy indicated daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 7	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (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;	0 480		

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0 480	Continued From page 8 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 9 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily	0 490		

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0 490	Continued From page 10 program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, at 10:30 a.m., during the entrance conference, the surveyor inquired if the licensee provided a daily program of social and recreational activities. Licensed assisted living director (LALD)-D stated the licensee offered activities twice a week but did not have a schedule of daily activities. On March 24, 2025, at 11:30 a.m., during the facility tour the surveyor did not observe a daily calendar of activities available for the residents. On March 24, 2025, between 9:45 a.m., and 3:00 p.m., the surveyor observed the residents remained in their rooms and only R2 frequented outside to smoke and when house (facility) idled around the table the surveyor was using. On March 25, 2025, at 1:20 p.m., LALD-D instructed ULP-C to take the residents for a walk. LALD-D called out to the residents. Three accepted to go, while one remained their room.	0 490		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

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EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

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0 490	Continued From page 11 On March 25, 2025, at 1:35 p.m., LALD-D and registered nurse (RN)-E stated understanding that even though they took out residents for a walk twice a week, they needed a daily calendar of activities and social recreation for the residents. The licensee's Activity Programming policy dated August 1, 2024, indicated on a regular basis, the licensee will provide a wide range of activities and social recreation for its residents. This programming will provide opportunities for residents and staff engagement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 630		

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0 630	Continued From page 12 licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on November 14, 2024, for assisted living services. R1's diagnoses included fetal alcohol syndrome, schizophrenia, generalized anxiety disorder, and high blood pressure. R1's Service Plan dated November 14, 2024, indicated R1 received the following services: medication administration, bathing assistance, hair care, grooming, dressing, housekeeping, and behavioral support. R4 R4 was admitted to the licensee on December 16, 2024, for assisted living services. R4's diagnosis included schizophrenia. R4's Service Plan dated December 16, 2024, indicated R4 received the following services: medication administration, linen change, grooming reminders, oral hygiene, housekeeping,	0 630		

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0 630	Continued From page 13 and behavioral support. R1 and R4's IAPPs were blank and lacked indication of any vulnerabilities or interventions to mitigate the likelihood of abuse due to vulnerabilities. On March 25, 2025, at 1:20 p.m., licensed assisted living director (LALD)-D stated both R1 and R4's IAPP were not completed, and that clinical nurse supervisor (CNS)-A was responsible for the nursing assessments. However, CNS-A was unavailable for interview as they were out on vacation. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2024, indicated the licensee would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 14 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a TB history and symptom screening, and TB training completed at hire for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's facility TB risk assessment dated March 1, 2025, indicated the facility was at a low risk for TB transmission. ULP-B started employment with the licensee on December 16, 2024, to provide direct care to the assisted living residents. ULP-B's record included a QuantiFERON-TB	0 660		

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0 660	Continued From page 15 gold plus (blood test) completed on December 30, 2024. ULP-B's record lacked a TB history and symptom screen, and TB training completed at hire, prior to providing services. On March 25, 2025, at 3:20 p.m., licensed assisted living director (LALD)-D stated clinical nurse supervisor (CNS)-A was responsible for TB screening and training, and they were not sure where those documents would be as CNS-A was on vacation. The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions (FAQs) dated June 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's Tuberculosis & Staff Screening policy dated July 1, 2024, indicated all home care staff whose essential job functions require work within the same air space of home care clients shall be screened and tested for tuberculosis. The policy also indicated the licensee will have health care worker education and health care worker screening for TB. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 16 (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 interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently. This had the potential to affect all four residents receiving services under the assisted living license, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - hazards identified by the facility's risk assessment and how the assessment was conducted; - maintain and annual EPP updates; - EPP program patient population; - process for EPP collaboration; - development of EPP policies and procedures; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On March 25, 2025, at 10:40 a.m., licensed assisted living director (LALD)-D stated the licensee was still working on their EPP to meet the requirement. When the surveyor requested to know why the licensee had not completed their EPP as it was cited in the previous survey,	0 680		

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0 680	Continued From page 18 LALD-D stated clinical nurse supervisor (CNS)-A had more information but was out on vacation. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 19 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 730		

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0 730	Continued From page 20 The findings include: R1 R1 was admitted to the licensee on November 14, 2024, for assisted living services. R1's Service Plan dated November 14, 2024, indicated R1 received the following services: medication administration, bathing assistance, hair care, grooming, dressing, housekeeping, and behavioral support. R4 R4 was admitted to the licensee on December 16, 2024, for assisted living services. R4's Service Plan dated December 16, 2024, indicated R4 received the following services: medication administration, linen change, grooming reminders, oral hygiene, housekeeping, and behavioral support. R1 and R4's records lacked documentation the following services were provided by the licensee as identified in the service plan: personal laundry, housekeeping, behavior support, bathing, grooming, dressing, meal preparation, okay checks, and linen change. On March 25, 2025, at 12:00 p.m., licensed assisted living director (LALD)-D stated they used WhatsApp (phone chat) to document services. LALD-D also provided some screen shots of the chat that included pictures and some information about R4's room cleaning. LALD-D stated the phone chat was for staff communication and that all four resident records would be lack documentation of services provided.	0 730		

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0 730	Continued From page 21 The licensee's Resident Record - Documentation policy dated August 1, 2024, indicated staff authorized to document in a resident record will do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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; (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;	0 780		

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0 780	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, from 12:30 p.m. to 1:45 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-C. Survey staff asked ULP-C to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarms in resident rooms were not interconnected with the other resident rooms. When the smoke alarms were tested in the hallway all alarms would sound. When resident room smoke alarms were tested only the room being tested and the hallway smoke alarms would sound. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all	0 780		

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0 780	Continued From page 23 alarms within the dwelling unit. The smoke alarm in the lower-level laundry room was chirping with a low battery alarm. Smoke alarms shall have batteries replaced at regular intervals to prevent malfunctions during loss of power to the facility. The hard-wired smoke alarm was missing from resident room 5. ULP-C stated that they did not know where the smoke alarm was. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 24 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-C. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections and annual certification of the fire extinguishers were completed. Portable fire extinguishers must be provided with monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. In an email dated March 25, 2025, at 9:55 a.m., the nurse evaluator emailed the surveyor a copy of an invoice from the facility indicating that the fire extinguishers were serviced on March 24, 2025. The invoice lacked any information to identify the facility address or name of licensee. The portable fire extinguishers in the facility were	0 790		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 25 not mounted to the wall or in a cabinet. Portable fire extinguishers shall be permanently mounted in a conspicuous location at least four inches off the floor and no higher than five feet above the floor to the top of the extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 26 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 March 24, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-C. The following was observed. There were tack strips for securing carpeting to the floor in resident rooms 3 and 4. The tack strips had small nails sticking up that could cause harm to residents. There tack strips were located around the outside walls of the resident rooms as well as at the transition from resident room 4 and the ensuite bathroom. In resident room 2 the hollow core doors used for the entry door as well as the closet door were split and delaminating. Licensed assisted living director (LALD)-D stated that the doors were damaged in a previous incident and that they had plans to replace the doors. LALD-D was not able to provide estimated timeline of repairs. In the common hallway on the first floor of the facility there was a missing light fixture. There were uncapped electrical wires sticking out of the open junction box on the ceiling. LALD-D stated that their maintenance person had removed the light fixture due to it no longer functioning. LALD-D also stated that their maintenance person was going to be replacing the missing light fixture. LALD-D was not able to provide an estimated timeline for completing the replacement of the light fixture. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 27 days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be 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	0 810		

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0 810	Continued From page 28 by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the 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 or has potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, registered nurse (RN)-E 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's FSEP, titled "9.06 Fire Policy", dated August 1, 2024, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide	0 810		

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0 810	Continued From page 29 complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The 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 plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. Licensed assisted living director (LALD)-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No other training documentation was provided. On March 24, 2025, at 2:00 p.m., LALD-D stated they did not have training records on site. LALD-D stated that they would email training records to the surveyor by 12:00 p.m. on March 25, 2025. No email has been received from the facility	0 810		

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0 810	Continued From page 30 providing training records as of March 28, 2025, at 1:19 p.m. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Log", indicated evacuation drills were conducted on October 18, 2024, December 17, 2024, and February 10, 2025. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 31 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee on December 16, 2024, to provide direct care to the	01370		

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01370	Continued From page 32 assisted living residents. On March 25, 2025, at 10:55 a.m., ULP-B stated they had completed a one-week caregiver training before they shadowed another ULP. ULP-B also stated they could not remember the topics covered in the training. ULP-B's training record lacked the following required content: TRAINING - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. COMPETENCY - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them.	01370		

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01370	Continued From page 33 On March 25, 2025, at 3:30 p.m., licensed assisted living director (LALD)-D stated all staff were trained and oriented at hire by clinical nurse supervisor (CNS)-A, using the same material. LALD-A also stated the same records would probably be missing for all employees. The licensee's Delegation of Assisted Living Services policy dated August 1, 2024, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of the assisted living services. The policy included training in all the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

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01380	Continued From page 34 required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee on December 16, 2024, to provide direct care to the assisted living residents. On March 25, 2025, at 10:55 a.m., ULP-B stated they had completed a one-week caregiver training before they shadowed another ULP. ULP-B also stated they could not remember the topics covered in the training. ULP-B's training record lacked the following required content: TRAINING - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and	01380		

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01380	Continued From page 35 - recognizing physical, emotional, cognitive, and developmental needs of the resident. COMPETENCY - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On March 25, 2025, at 3:30 p.m., licensed assisted living director (LALD)-D stated all staff were trained and oriented at hire using the same material. LALD-A also stated the same records would probably be missing for all employees. The licensee's Delegation of Assisted Living Services policy dated August 1, 2024, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of the assisted living services. The policy included training in all the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 36 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel within 30 calendar days of beginning to provide delegated tasks for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01440		

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01440	Continued From page 37 ULP-B started employment with the licensee on December 16, 2024, to provide direct care to the assisted living residents. On March 25, 2025, from 8:10 a.m., through 8:50 a.m., the surveyor observed ULP-B assist residents with breakfast and assist R2 and R4 with medication administration. ULP-B's record included documentation of medication administration training completed January 14, 2025. ULP-B's record lacked documentation of a 30-day supervision of performing a delegated task. On March 25, 2025, at 3:30 p.m., licensed assisted living director (LALD)-D stated ULP-B's 30-day supervision had not been completed. LALD-D also stated clinical nurse supervisor (CNS)-A kept track of the supervisions but was out on vacation. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2024, indicated staff who provide delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01460	Continued From page 38	01460		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced	01460		

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EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

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01460	Continued From page 39 by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) supervising direct services, completed orientation to assisted living statutes, before providing assisted living services, for one of one employee (RN-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-E started employment with the licensee on March 6, 2025, and supervised direct care of the assisted living residents. On March 24, 2025, at 10:30 a.m., during the entrance conference, RN-E stated they were new to the licensee. RN-E also stated they did not know much about the licensee's operations. On March 25, 2025, at 1:40 p.m., the surveyor observed RN-E assist a resident with first-aid care. RN-E's record lacked evidence RN-E completed orientation in the following topics: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors;	01460		

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01460	Continued From page 40 - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; - hearing loss training (optional); and - orientation to each specific resident and services provided. On March 25, 2025, at 12:30 p.m., licensed assisted living director (LALD)-D stated RN-E had yet to complete their assigned orientation topics. RN-E stated they were still learning to navigate the licensee's computer orientation. The licensee's Employee General Orientation policy dated August 1, 2024, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy also indicated the supervisor is responsible to ensure that proper orientation procedures and documentation are completed. However, the policy lacked the orientation topics to be completed at hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 41 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 42 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all required orientation topics to assisted living statutes before providing direct care services to residents for one of two employees (unlicensed personnel (ULP-B)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee on December 16, 2024, to provide direct care to the	01470		

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01470	Continued From page 43 assisted living residents. On March 25, 2025, from 8:10 a.m., through 8:50 a.m., surveyor observed ULP-B assist residents with breakfast and assist R2 and R4 with medication administration. ULP-B's education transcript dated December 21, 2024, indicated ULP-B had completed the following assisted living orientation topics: - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; and - handing of resident complaints, reporting of complaints, where to report. ULP-B's employee record lacked the following required assisted living orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; - hearing loss training (optional); - orientation to each specific resident and services provided (144G.63 Subd. 3). On March 25, 2025, at 3:30 p.m., ULP-B stated they completed all assigned training. However, could not remember the topics assigned to them. On March 25, 2025, at 3:40 p.m., licensed assisted living director (LALD)-D stated they had assigned ULP-B all the required orientation topics. When the surveyor inquired how the	01470		

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01470	Continued From page 44 licensee followed up to ensure the training was completed, LALD-D stated clinical nurse supervisor (CNS)-A was responsible and was out on vacation. The licensee's Employee General Orientation policy dated August 1, 2024, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy also indicated the supervisor is responsible to ensure that proper orientation procedures and documentation are completed. The policy lacked the specific orientation topics to be completed at hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 45 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 46 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C started employment with the licensee on August 29, 2023, to provide assisted living services. ULP-C's employee record indicated they had completed the following annual training topics: - assisted living bill of rights - 0.75 credits; - infection control techniques - 1 credit; - review of provider's policies and procedures - no credit; - principles of person-centered planning/service delivery - 0.75 credits; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 0.75 credits, for a total of 3.25 credits.	01500		

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01500	Continued From page 47 ULP-C's record lacked documentation of at least eight hours of annual training for each 12 months of employment and lacked the following topic: - reporting maltreatment of vulnerable adults or minors. On March 25, 2025, at 3:00 p.m., licensed assisted living director (LALD)-D stated the licensee had not completed annual training for the employees, and all the employee's records would be missing the same topic listed above. The licensee's Annual Require Staff Training policy dated May 1, 2024, indicated the following training elements must be included every 12 months to all staff who perform direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and	01500		

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01500	Continued From page 48 procedures, and; 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 49 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments within 14-days following the initiation of services for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving assisted living services on November 14, 2024. R1's diagnoses included fetal alcohol syndrome, schizophrenia, generalized anxiety disorder, and high blood pressure. R1's Service Plan dated November 14, 2024, indicated R1 received the following services: medication administration, nursing assessments, bathing assistance, hair care, grooming, dressing, housekeeping, and behavioral support. R1's record included an admission assessment dated, November 14, 2024, and a 90-day assessment dated February 12, 2025. R1's record lacked a 14-day reassessment completed within 14 days after initiation of services. On March 25, 2025, at 3:30 p.m., licensed assisted living director (LALD)-D stated 14-day	01620		

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01620	Continued From page 50 assessments were completed by clinical nurse supervisor (CNS)-A. LALD-D also stated CNS-A was out on vacation. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the unlicensed	01750		

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01750	Continued From page 51 personnel (ULP) were able to competently follow the procedure, for two of three employees (ULP-B, ULP-H). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B started employment with the licensee on December 16, 2024, to provide assisted living services. On March 25, 2025, at 8:55 a.m., the surveyor observed ULP-B administer two oral medications to R2. R2's medication administration record for March 2025, indicated ULP-B completed R2's medication administration in the mornings. On March 25, 2025, at 9:50 a.m., ULP-B stated they had been trained in medication administration by licensed assisted living director (LALD)-D. However, at 12:30 p.m., in the presence of LALD-D, ULP-B changed their statement and stated LALD-D trained them at first and about three or four days later clinical nurse supervisor (CNS)-A trained them again. ULP-H	01750		

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01750	Continued From page 52 ULP-H started employment with the licensee on August 22, 2024, to provide assisted living services. On March 25, 2025, at 2:03 p.m., over a phone interview with the surveyor and LALD-D, ULP-H stated they were trained by LALD-D in medication administration. ULP-H also stated they had not met the nurse as they worked only nights and weekends. R2's medication administration record for March 2025, indicated ULP-H completed R2's medication administration in the nights and mornings. ULP-B and ULP-H's employee records lacked evidence of medication training and/or demonstration of competency before they administered medications to residents. The licensee's CNS was unreachable for interview as they were on vacation and the RN on site did not have awareness of the training process used for ULP-B and ULP-H because they were new to the licensee. On March 25, 2025, at 2:10 p.m., LALD-D stated the medication administration training was completed by CNS-A and ULPs only shadowed LALD-D once they were trained. LALD-D also stated they were not sure why the ULPs kept saying they were trained by them. The licensee's Medication Management Services Provided by ULPs policy dated July 1, 2014, indicated a RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a client's	01750		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

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01750	Continued From page 53 medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the client. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. The policy also indicated ULP must demonstrate their ability to competently follow the delegated medication administration to a RN, and that written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	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 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	01760		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

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01760	Continued From page 54 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 accurately document medications administered for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on November 14, 2024, for assisted living services. R1's diagnoses included fetal alcohol syndrome, schizophrenia, generalized anxiety disorder, and high blood pressure. R1's Service Plan dated November 14, 2024, indicated R1 received the following services: medication administration, bathing assistance, hair care, grooming, dressing, housekeeping, and behavioral support. On March 25, 2025, at 9:14 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare to administer medications to R1. ULP-B stated	01760		

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01760	Continued From page 55 the medications were not entered in R1's electronic medication administration record (eMAR). ULP-B also stated licensed assisted living director (LALD)-D had instructed them to administer the medication even though they were not in R1's eMAR. Registered nurse (RN)-E intervened and stopped ULP-B from administering the medications to R1, until they could get clarification from the provider. RN-E went through R1's record and was able to find only one written order for prenatal tablet 27-0.8 milligram (mg) take once daily by mouth dated January 31, 2025. On March 25, 2025, at 9:40 a.m., ULP-B stated R1 was admitted to hospital on March 18, 2025, stayed overnight, and was discharged the following day with three medications. The surveyor requested the hospital discharge paperwork. LALD-D then stated R1 had broken into their document storage cabinet, took her file and ripped out documents, including the hospital discharge paperwork. On March 25, 2025, at 10:14 a.m., the surveyor observed R1's medication, pre-packaged from the pharmacy, included the following: -prenatal tablet 28-0.8 milligram (mg) take once daily, -aspirin 81 mg take one tablet by mouth daily, -nifedipine ER 30 mg tablet take one tablet by mouth once daily, -prenatal multivitamin with folate, -labetalol hcl 200 mg take one tablet by mouth along with 100 mg three times daily, -labetalol hcl 100 mg tablets take one tablet three times daily, and -Ferosul 325 mg take one tablet by mouth once daily with breakfast.	01760		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 56 R1's record lacked documentation of administration of the previous-listed medications for March 2025. On March 25, 2025, at 3:30 p.m., LALD-D stated the licensee was in the process of switching from their current documentation system to Rtask (documentation software). LALD-D also stated they believed R1's record had been transferred to the new system. The surveyor requested LALD-D to check in the other system however, there was no medication administration record available for R1 for the month of March 2025, in either system. The licensee's Medication Administration - Documentation policy dated July 1, 2014, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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	30500	A. BUILDING: _____ B. WING _____	03/27/2025

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01910	Continued From page 57 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R3 was discharged from the licensee on December 3, 2024. R3's Service Plan dated November 18, 2024, indicated R3 received the following services:	01910		

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01910	Continued From page 58 housekeeping, personal laundry, medication administration, and medication reminders. R3's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On March 25, 2025, at 3:30 p.m., licensed assisted living director (LALD)-D stated R3 was given all their medication at discharge. LALD-D also stated they did not keep record of the medications given to R3 at discharge as they were not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display	03090		

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03090	Continued From page 59 statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. 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 March 24, 2025, at 11:20 a.m., during a facility tour, the surveyor observed the licensee lacked a posted electronic monitoring notice at the entrance, accessible to visitors, including the following verbiage: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On March 26, 2025, at 12:30 p.m., licensed assisted living director (LALD)-D stated the licensee was aware of the requirement, but they forgot to post the signage. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *03/24/25*
Time: 10:30:00
Report: 1051251077

Food and Beverage Establishment Inspection Report

Location:

Evensong Manor
6264 Yukon Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0038727
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129400621
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.

4-200 Equipment Design and Construction

4-204.112D

MN Rule 4626.0620D Provide a temperature measuring device that is easily readable.

AT TIME OF INSPECTION, THERE IS NO THERMOMETER INSIDE THE UPRIGHT COOLER.

Comply By: 03/25/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

AT TIME OF INSPECTION, THE KITCHEN DISHMACHINE WAS BROKEN ON 3/23/24. REPLACE OR REPAIR THE EQUIPMENT. SET UP A CONTAINER OF SANITIZER TO UTILIZE PROPER WASH, RINSE, & SANITIZE FOR WASHING DIRTY DISHES UNTIL EQUIPMENT IS FIXED.

Comply By: 04/07/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE A HANDWASH SIGN FOR THE EMPLOYEE RESTROOM.

Comply By: 03/24/25

Type: Full
Date: *03/24/25*
Time: 10:30:00
Report: 1051251077
Evensong Manor

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SLICED AMERICAN CHEESE
Violation Issued: No

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

MET WITH NURSE EVALUATOR, BENARD NYANGENA.

DISCUSSED THE FOLLOWING WITH THE STAFF, DJ:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE

THE KITCHEN HAS A NSF 184 DISHMACHINE, VINYL PLANK FLOORS, A SMOOTH TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, AND LAMINATE CABINETS.

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 1051251077 of 03/24/25.

Certified Food Protection Manager: Yasmin Mohamed

Certification Number: FM118759 Expires: 07/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
DJ

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us