Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

September 18, 2025

Licensee
Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719

RE: Project Number(s) SL30680016

Dear Licensee:

Please note: This letter amends the previous notice dated August 13, 2025. The total amount of fines you were assessed has been corrected. You have the right to request a reconsideration or a hearing, within the statutory timeline, based on the date of the new letter. No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on June 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

AH

Electronically Delivered

August 13, 2025

Licensee
Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719

RE: Project Number(s) SL30680016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

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https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

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

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30680160 On June 23, 2025, through June 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 29 residents receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure weekly menus were made available to the residents, in three of three houses (one, two, three). This had the potential to affect all 29 residents. 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	0 485		

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0 485	Continued From page 4 or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 23, 2025, at approximately 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-C stated the licensee provided three meals daily to include fresh fruits and vegetables, snacks were offered, alternates available, residents had input with menus, and menus were posted. During a tour of the facility on June 23, 2025, at approximately 10:15 a.m., the surveyor observed that the facility was separated into three houses (one, two, three) joined by an outdoor common's area. In each house the surveyor observed a single-day menu written on a white board near each kitchen. On June 23, 2025, at 10:27 a.m., RN-C stated the weekly menus were to be posted under the activity schedule. RN-C confirmed weekly menus were not posted as required in any of the three houses. In addition, RN-C stated the weekly menus were not given to the residents. The licensee's Food Service & Menu Planning policy dated March 5, 2025, noted menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 510	Continued From page 5	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP)-B while providing assistance to one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was hired on October 20, 2017, to provide direct care services to the facility's residents. On June 24, 2025, at 6:31 a.m., the surveyor	0 510		

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0 510	Continued From page 6 observed ULP-B and ULP-F assist R7 to a standing position. With gloved hands ULP-B removed the wet incontinence brief worn by R7 and put the brief into a trash can. ULP-B used a prepared (moistened) wash cloth to clean R7's peri area. ULP-B tossed the used washcloth on R7's carpeted floor. ULP-B dried R7's peri area with a clean and dry towel. ULP-B tossed the used towel on R7's carpeted floor. ULP-B pulled a clean brief up that had been positioned under R7's pants. ULP-F picked up the used towels from R7's floor. On June 24, 2025, at 12:04 p.m., registered nurse (RN)-C stated ULPs should not put used, dirty towels on resident's carpet. RN-C stated she had instructed ULPs to "drape" used towels over trash cans. The licensee's Standard Precautions policy dated March 5, 2025, noted standard precautions apply to exposure to all body fluids, secretions, and excretions, except sweat, regardless of whether they contain visible blood. Further all linen shall be handled using standard precautions. The licensee's Pathogen Exposure Control Plan dated March 5, 2025, noted standard precautions represent the minimum infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare was delivered. Precautions include safe handling of potentially contaminated equipment or surfaces in the environment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 550 SS=D	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure in one of three houses (house one). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 550		

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0 550	Continued From page 8 During a tour of the facility on June 23, 2025, at 10:25 a.m., with registered nurse (RN)-C the surveyor did not observe information about the facility's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances in house one. RN-C stated there was a binder that normally was located on the counter near the kitchen, which contained the licensee's grievance procedure. RN-C stated the binder was not where it was supposed to be. RN-C went into the kitchen and opened a cabinet. RN-C stated the binder was too high for her (RN-C) to reach. RN-C asked director of maintenance (DM)-D to obtain the binder. RN-C stated someone must have put the binder in the cabinet. RN-C confirmed the required information was not in a conspicuous place as required. The licensee's Compliant/Grievance Posting policy dated March 5, 2025, noted the licensee would post, in a conspicuous place, information about the licensee's complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for	0 640		

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	30680	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 640	Continued From page 9 reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number in common areas and by telephones for resident use in the facility in three of three houses (one, two, three). This had the potential to affect residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a tour of the facility on June 23, 2025, at approximately 10:15 a.m., the surveyor observed that the facility was separated into three houses (one, two, three) joined by an outdoor common's area. The surveyor did not observe 911 posted in any of the common area or on or near telephones	0 640		

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0 640	Continued From page 10 available for resident use, in any of the three houses. On June 23, 2025, at 10:29 a.m., registered nurse (RN)-C stated 911 might be in a binder? RN-C looked in a binder and stated 911 was not noted in the binder. In addition, RN-C looked on a cordless phone that was available for resident's use. RN-C stated 911 was not posted on or near the cordless phone. RN-C stated 911 was not posted in any of the three common's area or on or near telephones available for resident's use as required. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated March 5, 2025, noted the licensee would post the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 11 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of two employees (unlicensed personnel (ULP)-E, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 23, 2025, at 10:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-C stated the licensee was aware of required contents of employee records.	0 650		

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0 650	Continued From page 12 ULP-E ULP-E was hired on December 23, 2020, to provide direct care services to the facility's residents. TILT-N-SPACE WHEELCHAIR (wheelchair that allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure) On June 24, 2025, at 5:53 a.m., the surveyor observed ULP-E and ULP-G transfer R6 from a sit to stand lift (mechanical lift) into a tilt-n-space wheelchair. On June 24, 2025, at 5:58 a.m., ULP-E asked R6 if he was comfortable, are you leaning back far enough, do you want to lean back more? Do you want the footrests on? ULP-E used the controls on the wheelchair handles to tilt R6's chair. ULP-E's employee record did not include documentation of training and competency for tilt-n-space wheelchair. ULP-H ULP-H was hired on August 8, 2021, to provide direct care services to the facility's residents. On June 24, 2025, at 10:50 a.m., the surveyor observed ULP-H place R5's feet onto the foot plate of a sit-to stand lift. ULP-H placed R5's hands onto the sit-to stand lift also. ULP-H asked R5 to open her (R5's) eyes. ULP-H stated she was trying to get R5 to wake up. R5's diagnoses included Alzheimer's dementia.	0 650		

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0 650	Continued From page 13 R5's service plan dated September 22, 2021, indicated R5 received the following services: - protective boots at night and assistance with personal cares. PROTECTIVE BOOT R5's prescriber order dated June 8, 2025, included, protective boot right foot at night. R5's treatment record dated June 1, 2025, though June 23, 2025, included: -protective boot right foot at night. ULP-H's employee record did not include documentation of training and competency for R5's protective boot. ICE PACKS R5's prescriber order dated June 8, 2025, included: - may use ice packs for 20 minutes every hour as needed to swollen areas immediately following a fall or minor burns. ULP-H's employee record did not include documentation of training and competency for ice packs. On June 24, 2025, at 12:56 p.m., RN-C state there was no documentation of tilt-n-space training and competency, protective boots, or ice pack use in any of the ULP's records. RN-C stated she did train and deem all ULPs competency of these tasks, but she did not document it. RN-C stated she had one more place she could look in ULP's record for the above noted delegated tasks. RN-C was not able to locate any documentation of the above noted training or competencies.	0 650		

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0 650	Continued From page 14 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Employee Records policy dated March 5, 2025, noted employee records for each person would include: - records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's Training Records policy dated March 5, 2025, noted the licensee would document each competency evaluation, training, retraining, and orientation topics.	0 650		

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0 650	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 23, 2025, from 12:30 p.m. to 2:45 p.m., with director of maintenance (DM)-D, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR SPECIAL LOCKING	0 775		

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0 775	Continued From page 16 ARRANGEMENTS There was delayed egress door locking systems provided in all three separate buildings at the main marked exit door exiting to the public way. The delayed egress door locking systems were not provided with a switch located at the nurse office/station or other approved location to release the door locking system to the open position to exit the building in the event of an emergency. During an interview on June 23, 2025, at 12:30 p.m., with DM-D, documentation was requested indicating procedures of operation for the delayed egress door locking systems. DM-D, stated documentation was not available in the fire safety evacuation plan indicating the procedures required to operate the door locking system in each building. It was explained to DM-D, during the tour and interview that a switch to deactivate the door locking system is required to be installed at the nurse station or other approved location. It was also explained the procedures of operation of the delayed egress locking systems are required to be included in the fire safety and evacuation plan. CARBON MONOXIDE ALARMS There was one carbon monoxide alarm installed outside the resident sleeping rooms in both corridors of building one. The installed carbon monoxide alarms were not installed with ten feet of each sleeping room. It was explained that carbon monoxide alarms are required to be installed outside and within 10 feet of all sleeping rooms.	0 775		

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0 775	Continued From page 17 MARKED EXIT DOOR OPERATION The main marked exit door of building one was provided with a panic bar and additional dead bolt requiring to actions to exit in the event of a fire or similar emergency. It was explained to DM-D, that required marked exit doors shall required one operation to open to exit the building in the event of an emergency. EXTERIOR EXIT GATE There were exterior exit doors from each building leading to a courtyard with an exterior exit gate which was operatable with hardware on the outside (non-egress) side of the gate only. During the tour DM-D, stated the exterior exit gate was not openable from the inside (egress) side. DM-D, also stated exit signs would be installed on the doors leading through the intervening buildings. SMOKE ALARM MAINTENANCE The smoke alarms in building two were removed by DM-D, to verify year of manufacture. It was observed the smoke alarms were manufactured in 2009 and 2010. During the tour DM-D, stated they will be replacing the alarms in building two to be maintained within ten years of manufacture and check manufacture dates on alarms in the other to buildings to maintain all alarms within ten years of manufacture. It was explained to DM-D, that all smoke alarms are required to be maintained within ten years of manufacture date stamped on the alarm.	0 775		

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0 775	Continued From page 18 EXIT SIGN/ EMERGENCY LIGHT MAINTENANCE During the tour the test buttons were activated on the lighted exit signs throughout all three buildings and did not operate as required to provide emergency backup power to the combination exit signs/emergency lights. It was explained that exit signs and emergency lights are required to be provided with backup power in the event of a power failure. DM-D, stated new exit lights/ emergency lights were on order. FIRE EXTINGUISHER SIGNAGE The fire extinguishers were observed in the kitchen but were not visible from the occupied space outside the kitchen without entering the kitchen. It was explained to DM-D, that fire extinguishers are required to be visible to all building occupants or have signage installed to identify the fire extinguisher location. CEILING LIGHT FIXTURE MAINTENANCE There was a ceiling light fixture cover missing in building one resident room one. It was explained to DM-D, that ceiling light fixture covers are required to be maintained in place according to manufactures instructions and MSFC in Minnesota Rules Chapter 7511. During the facility tour DM-D, verified the above listed observations while accompanying on the tour.	0 775		

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0 775	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780		

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0 780	Continued From page 20 failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms and interconnected smoke alarms throughout each individual building. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: INTERCONNECTION On a facility tour on June 23, 2025, from 12:30 p.m. to 2:45 p.m., with director of maintenance (DM)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout building one. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and DM-D, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout building one. OUTSIDE OF SLEEPING ROOMS On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of sleeping room eight in	0 780		

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0 780	Continued From page 21 building three. The smoke alarm wiring was hanging from the ceiling, but the smoke alarms was not installed as required. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. During the tour DM-D, verified smoke alarms were not installed outside in the immediate vicinity of resident room eight in building one. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=E	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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 22 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). Findings include: On a facility tour on June 23, 2025, from 12:30 p.m. to 2:45 p.m., with director of maintenance (DM)-D, the surveyor made the following observations of facility disrepair: LIGHT FIXTURE MAINTENANCE There were light bulbs missing exposing the power outlet on the vanity light fixture in resident sleeping room two house three and resident sleeping room eight house two. It was explained to DM-D, that light bulbs are required to be maintained in place to prevent accidental contact to building power in the empty socket by building occupants. BATHROOM EXHAUST FAN MAINTENANCE The bathroom exhaust fan switch was turned on and the fan did not operate as required in the bathroom of resident room eight building two. It was explained to DM-D, that bathroom exhaust fans are required to be maintained in order to remove moisture from the bathroom and maintain air quality. During the facility tour DM-D, verified the above listed observations while accompanying on the	0 800		

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0 800	Continued From page 23 tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and 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.	0 810		

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	30680	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

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0 810	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required training to residents. 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 June 23, 2023, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the training was provided to residents as required. During an interview on June 23, 2025, at 12:10 p.m., LALD/CNS-A, stated written documentation was not available indicating residents were provided training annually as required.	0 810		

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0 810	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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01060	Continued From page 26 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnosis included depression, and chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation).	01060		

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01060	Continued From page 27 R2's service plan dated September 22, 2021, indicated R2 received medication administration four times daily, hands on assistance with transfers and mobility, assistance with dressing twice daily, assistance with oral hygiene and hair care, oxygen as needed (PRN) and housekeeping services. On June 23, 2025, at 9:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A supplied the surveyor with a current resident roster. LALD/CNS-A had placed an asterisk in front of R2's name on the roster. LALD/CNS-A stated R2 was currently out of the facility, at the hospital. LALD/CNS-A stated R2 went into the hospital with COPD and blood pressure issues. LALD/CNS-A stated R2 had been away from the facility for greater than four days. The surveyor asked LALD/CNS-A if the required paperwork had been completed and notifications given. LALD/CNS-A stated R2 went to the clinic and the clinic sent her (to the hospital). LALD/CNS-A stated she misunderstood the requirement. R2's record included a nurses note dated June 9, 2025, that noted: - scheduled PCP (primary care provider) appointment for weakness and congestion. Sent to (name of hospital) to be admitted with COPD exacerbation, guardian notified. On June 23, 2025, at 10:17 a.m., LALD/CNS-A stated R2 was the only one (resident) who had ever been out of the facility for greater than four days. LALD/CNS-A stated most to the time a resident was out "for a day or two tops". On June 24, 2025, at 6:07 a.m., the surveyor introduced herself to R2. R2 stated she had been	01060		

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01060	Continued From page 28 gone for "about 15 days" but was now on the mend to health. On June 24, 2025, at 11:24 a.m., the surveyor observed R2 sitting at the dining room table. R2 wore a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) and an oxygen concentrator was positioned near R2. An alarm sounded from R2's oxygen concentrator and the surveyor observed unlicensed personnel (ULP)-H go to the oxygen concentrator. R2's record lacked a written notice that contained, at a minimum: - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. The licensee's Emergency Relocation policy dated March 5, 2025, noted in the event of an emergency relocation, (facility name) would provide a written notice that contained, at a minimum: a. The reason for the relocation	01060		

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01060	Continued From page 29 b. The name and contact information for the location to which the resident had been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known, and e. A statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290		

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01290	Continued From page 30 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 30280) for three of 39 employees (unlicensed personnel (ULP)-J, ULP-K, ULP-L). 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 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: During the entrance conference on June 23, 2025, at 9:50 a.m., the surveyor requested a NETStudy background report (online system used by the Minnesota Department of Human	01290		

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01290	Continued From page 31 Services (DHS) to process BGS for individuals seeking to work in care-based settings) for all the employees providing care at the assisted living facility. On June 23, 2025, at 1:54 p.m., the NETStudy report supplied to the surveyor was reviewed with registered nurse (RN)-C. ULP-J ULP-J was hired on July 19, 2024, to provide direct care services to the residents. ULP-J's employee record included a BGS dated June 22, 2025, for HFID 37901. ULP-J's employee record lacked documentation of a cleared BGS for HFID 30280. ULP-K ULP-K was hired on July 2, 2024, to provide direct care services to the residents. ULP-K's employee record included a BGS dated October 29, 2024, for HFID 37901. ULP-K's employee record lacked documentation of a cleared BGS for HFID 30280. ULP-L ULP-L was hired on August 4, 2023, to provide direct care services to the residents. ULP-L's employee record included a BGS dated April 7, 2024, for HFID 37901. ULP-L's employee record lacked documentation of a cleared BGS for HFID 30280. On June 24, 2024, at 10:08 a.m., licensed	01290		

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01290	Continued From page 32 assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed background study reports with the surveyor. LALD/CNS-A stated ULP-J, ULP-K, and ULP-L's BGS needed to be affiliated with HFID 30280. LALD/CNS-A confirmed ULP-J, ULP-K, and ULP-L's background studies were not affiliated with HFID 30280. The licensee's Background Studies policy dated March 5, 2024, noted no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study had been received. - using the MN DHS (Minnesota Department of Human Services NETStudy online program, the licensee would indicate a background study on all employees being considered for hire -if hired prior to receiving the results of the background study, or the tentative background study results indicated more time was needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients (residents) of the licensee except under the direct supervision (eyesight) of another qualified staff person - once an approved background study had been received. staff may act undependably with residents, assuming all other requirements had been met - copies of completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01620	Continued From page 33	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 34 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current status for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R5's diagnoses included Alzheimer's dementia. R5's service plan dated September 22, 2021, indicated R5 received the following services: - assistance with feeding, cut and arrange with all meals	01620		

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01620	Continued From page 35 - prepare modified diet, dated June 9, 2025 (dated noted by entry), PRN (as needed or desired) blend/grind food - hands-on assistance with transfers and mobility: every day and PRN, standard wheelchair and standing lift - feeder at meals. On June 23, 2025, at 11:34 a.m., the surveyor observed unlicensed personal (ULP)-M use a food processor to prepare R5's noon meal. In addition, an unidentified person sat next to R5. On June 24, 2025, at 7:43 a.m., the surveyor observed ULP-M prepare R5's meal. ULP-M turned the food processor on, turned the food processor off, added milk to the mixture, and turned the food processor on again. On June 24, 2025, at 11:21 a.m., ULP-H stated R5's had been on a "grind diet" for a while now. R5's undated Resident Care Plan noted: - transfers, standing lift - diet general/soft - assist with meals/feeder - PRN blend/grind food. R5's record included nurses notes: - February 26, 2021, request for UA (urinary analysis), UTI (urinary tract infection) pending. Start Bactrim (type of antibiotic that contains sulfamethoxazole and trimethoprim) - March 1, 2021, UTI culture back, see orders, discontinue Bactrim and start Macrobid (antibiotic used to treat UTI) - May 18, 2022: UA sent due to UTI symptoms, see orders - May 18, 2022: UA sent related to UTI symptoms, see antibiotic order	01620		

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01620	Continued From page 36 - February 9, 2022: weakness with cloudy urine. Order for antibiotic, UTI - February 13, 2023, UA sent in related to signs and symptoms UTI, see antibiotic order - February 7, 2024, to see (name of provider) for lower back pain. diagnosis UTI, started on antibiotics - May 18, 2025: antibiotics for UTI symptoms. R5's prescriber order dated June 9, 2025, noted, diet, regular: - blend/grind PRN (as desired or as needed) R5's 90-day assessment dated May 6, 2025, noted: -gait belt transfers - no history of UTI - diet texture: regular (mechanical soft, pureed, other not checked) - eating: no devices. R5's 90-day assessment did not reflect R5's current status. On June 24, 2025, at 11:55 a.m., RN-C stated R5's assessment was incorrect. RN-C stated she reviewed R5's prior assessment, completed on February 11, 2025, and "missed" a few items. RN-C stated R5's assessment did not include sit to stand lift need and history of UTIs. RN-C stated R5's diet change was PRN. RN-C stated R5's incorrect assessment was an isolated issue. The licensee's Assessment Schedules policy dated March 5, 2025, noted ongoing resident reassessment and monitoring was be done as needed based on charges in the needs of the resident but could not exceed 90 calendar days from the last date of the assessment. changes in client (resident) condition assessment would be	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 37 completed as indicated, in-person or via telecommunications if necessitated by geographic or distance or urgent/unexpected circumstance. The lionesses Uniform Assessment Tool policy dated March 5, 2025, noted the licensee would use a uniform assessment tool that addressed all the required elements to include: - mobility, including ambulation, transfers, and assistive devices - eating, and assistive devices - risk for dehydration including history of urinary tract infections and current fluid intake pattern. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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	30680	A. BUILDING: _____ B. WING _____	06/25/2025

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01640	Continued From page 38 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plan revisions included a signature or other authentication by the resident documenting agreement on the services to be provided for one of one resident (R5). In addition, the licensee failed to ensure service plans were revised to include provided services for one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: REVISIONS TO INCLUDE SIGNATURE BY THE RESIDENT R5 R5's diagnoses included Alzheimer's dementia. R5's service plan dated September 22, 2021, indicated R5 received the following services: - assistance with feeding, cut and arrange with all meals - hands on assistance with transfers and mobility:	01640		

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01640	Continued From page 39 every day and PRN (as needed or as desired) - standard wheelchair and standing lift - feeder at meals - treatments and exercise: N/A (not applicable) - treatments and therapies: protective boots at night - dated June 9, 2025 (date noted by entry): prepare modified diet, PRN blend/grind food. On June 23, 2025, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-M use a food processor to prepare R5's noon meal. R5's service plan revision did not include a signature or other authentication by the resident documenting agreement of the services provided. On June 24, 2025, at 11:50 a.m., the surveyor reviewed R5's service plan with registered nurse (RN)-C. RN-C stated she did not know that each time a service was changed (added or removed) the resident or the resident's representative needed to sign the service plan. RN-C stated they (nurses) always updated the resident or the resident's representative of services provided, but they (licensee) did not have them (resident/resident's representative) sign the service plan each time a change was made. RN-C stated this was a widespread issue. REVISIONS TO SERVICE PLANS R7 R7's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), pneumonia, wheezing, anxiety, and pain. R7's service plan dated September 16, 2021, included: - assistance with dressing, two times daily and	01640		

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01640	Continued From page 40 PRN (as needed or desired). On June 24, 2025, at 6:31 a.m., the surveyor observed ULP-B and ULP-F assist R7 to a standing position. The surveyor observed a pair of compression hose on the floor near R7's recliner. ULP-F stated he just applied a clean pair of compression hose to R7's legs. R7's treatment administration record (TAR) dated June 1, 2025, through June 12, 2025, noted: - compression hose on in a.m., (morning) off at bedtime. R7's prescriber order dated April 24, 2025, included the above order. R7's service plan was not revised to include compression hose daily. On June 25, 2025, at 9:24 a.m., R7's service plan was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she did not "see" (locate) compression hose on R7's service plan as required. LALD/CNS-A confirmed R7's service plan had not been revised as required. The licensee's Service Plan policy dated August 1, 2021, noted the service plans should be revised, if needed, based on resident reassessments and monitoring. Service plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R5's diagnoses included Alzheimer's dementia. R5's service plan dated September 22, 2021, indicated R5 received medication administration	01750		

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01750	Continued From page 42 three times daily and PRN (as desired or as needed). On June 23, 2025, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-M use a food processor to prepare R5's noon meal. ULP-M turned the unit on, turned the unit off, added milk to the mixture, and turned the machine on again. In addition, an unidentified person sat next to R5 and fed R5. On June 24, 2025, at 11:21 a.m., ULP-H stated she (ULP-H) had just given R5 her noon medication crushed in yogurt. ULP-H added, R5 had been on a "grind diet for a while now, but, once and a while R5 could feed herself". R5's June 1, 2025, through June 23, 2025, medication administration record (MAR) included: - senna 8.6 milligrams (mg) (constipation) twice daily - Aricept 10 mg (dementia) daily - synthroid 88 micrograms (mcg) (hypothyroidism) daily half hour before meals - calcium 600 mg (health maintenance) daily - aspirin 81 mg (health maintenance) daily - zinc 50 mg (health maintenance) daily - ibuprofen 800 mg one tablet every eight hours PRN for pain. R5's prescriber order dated June 9, 2025, included the above orders. CRUSHED MEDICATION R5's MAR did not include directions to crush R5's medications. On June 24, 2025, at approximately 11:20 a.m., registered nurse (RN)-C stated ULPs were able to crush R5's medications based off the facility's	01750		

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01750	Continued From page 43 standing orders, which noted, "when resident is unable to swallow medication; they may be crushed and mixed with food. RN-C stated R5's MAR did not include directions for ULPs to crush R5's medication. RN-C pointed to an area on R5's MAR which noted, "special notes". RN-C stated R5's MAR should have included, under the special notes area, crush resident's medication. RN-C confirmed not all medications were to be crushed, and R5's record did not include specific written instructions for medication administration. IBUPROFEN R5's June 2025, MAR included: ibuprofen 800 mg administered - June 4, 2025 - June 5, 2025 - June 15, 2025. R5's MAR did not include specific instructions for R5's ibuprofen 800 mg. On June 24, 2025, at 11:43 a.m., the manufacturer's instructions were reviewed with RN-C. RN-C stated R5's record should have included to give ibuprofen with food or milk. Manufacturer's instructions dated October 3, 2023, noted ibuprofen may cause stomach or intestinal bleeding, which can be fatal. These conditions can occur without warning while you are using the medication, especially in older adults. Take ibuprofen with food or milk to lessen stomach upset. The licensee' Medication and Treatment Administration policy dated March 5, 2025, noted a RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the resident's	01750		

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01750	Continued From page 44 record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed correctly at the time of set up for one of one resident (R3) with records reviewed. 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 June 23, 2025, at 10:03 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (CNS)-A and	01770		

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01770	Continued From page 45 registered nurse (RN)-C stated the licensee provided medication set up services for residents who received Coumadin (blood thinner) administration. RN-C stated they (facility) had packing from the pharmacy and Coumadin was set up by the licensee in a bubble pack, the same as other medications. R3's diagnosis included TIA (brief blockage of blood flow to the brain) due to embolism (blood clot, air bubble, or fat particle, travels through the bloodstream and blocks a blood vessel). R3's service plan dated July 9, 2024, included weekly warfarin (Coumadin) set up by RN. R3's medication administration (MAR) dated June 1, 2025, through June 31, 2025, included: - warfarin 5 milligrams (mg) by mouth 5:00 p.m. (documented as administered by ULPs evidenced by ULP's initials via daily documentation June 1, 2025, through June 22, 2025: and - daily by RN, anticoagulant (documented as set up June 1, 2025, thorough June 31, 2025, via RN's initials). R3's prescriber order dated June 17, 2025, included the above order; and - 7.5 mg every M (Monday), F (Friday): and noted - next INR (a standardized measurement used to assess blood clotting time) check June 26, 2025. R3's records lacked documentation for medication setup at the time of setup to include the correct dates of medication setup, and correct dosage. On June 23, 2025, at 10:35 a.m., during a tour of the facility the surveyor observed several medication bubble packs in a bin for R3, to	01770		

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01770	Continued From page 46 include a medication card labeled Coumadin with medication information (pharmacy label). RN-C stated she set up R3's Coumadin. RN-C stated the facility used the same bubble packs as the pharmacy did, so not to confuse staff. R3's June MAR was reviewed with RN-C. RN-C stated she should not be documenting the medication as set up prior to receiving orders. RN-C stated she documented Coumadin as set up, so she would not forget. RN-C stated R3 received the correct dosage of Coumadin, regardless of documentation. RN-C stated three residents received Coumadin set up and all of set ups were completed the same way. RN-C confirmed medication set up was a widespread issue. The licensee's Medication Management-Administration & Setup policy dated March 5, 2025, noted documentation of a medication reminder, medication assistance or medication administration would be completed immediately after that task had been performed. Further, the licensed nurse who sets up the medication in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up. In addition, a licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was securely stored and permitted only authorized personnel to have access to medication being stored by the licensee for two of four residents (R7, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R7 R7's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), pneumonia, wheezing, anxiety, and pain. R7's service plan dated September 16, 2021, indicated R7 received medication administration four times daily.	01880		

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01880	Continued From page 48 R7's Medication/Treatment/Therapy Management Plan dated March 17, 2025, included: - medications would be: securely stored by the provider located: locked medication room for provider ordered medication - can be accessed by provider staff - OTC's (over the counter medications) could be stored in client (resident) bedroom, and bedroom was locked at all times. DUONEB On June 24, 2025, at 6:29 a.m., the surveyor observed ULP-B remove a DuoNeb 0.5-3 (2.5) milligram (mg)/3 milliliter (ml) nebulizer vial (pneumonia) from R7's medication storage bin from a secured area. ULP-B took the DuoNeb vial to R7's room. ULP-B placed the unopened DuoNeb vial on a side table in R7's room. ULP-B and ULP-F assisted R7 into a chair. On June 24, 2025, at 6:36 a.m., ULP-B left R7's room. R7's unopened DuoNeb vial remained on a side table in R7's room unsecured. On June 24, 2025, at 6:38 a.m., ULP-B returned to R7's room and administered R7's DuoNeb. On June 24, 2025, at 7:13 a.m., ULP-B stated she should not have left the DuoNeb vial in R7's room when she (ULP-B) left the room. On June 24, 2025, at 11:25 a.m., registered nurse (RN)-C stated R7's DuoNeb should not have been left unattended in R7's room. VANI-CREAM On June 24, 2025, at 6:30 a.m., the surveyor observed an opened container of Vani Cream skin care cream (fragrance-free formulated for sensitive skin) that had a pharmacy label	01880		

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01880	Continued From page 49 attached to the container in R7's living area unsecured. R7's Vani-Cream was not in locked bedroom. On June 24, 2025, at 12:05 p.m., RN-C stated any medication that had a prescriber's order (pharmacy label) for should be kept in the locked medication room. RN-C added nursing was responsible for reordering medications. RN-C confirmed R7's Vani Cream was not in R7's locked bedroom. R4 R4's diagnoses included diabetes. R4's service plan dated indicated R7 received medication administration four times daily. R4's Medication/Treatment/Therapy Management Plan dated March 17, 2025, included: -independent with OTC medications - OTC's (over the counter medications) could be stored in client (resident) bedroom, and bedroom was locked at all times. On June 24, 2025, at 7:16 a.m., the surveyor observed ULP-N administer R4's medication using correct technique. The surveyor observed an opened Vicks Vapor Rub (product that is applied to the skin. When applied to the chest, inhaling the vapors of this product may provide temporary relief of cough cause if by irritation of the throat or lungs) container and a bottle of Visine eye drops (reduce eye redness) on a side table in R4's room. R4's Vicks Vapor Rub and Visine eye drops were not in locked bedroom. On June 24, 2025, at 7:22 a.m. ULP-N stated the Vicks Vapor Rub in R4's room was for her (R4's) "personal use." ULP-N added R4 went up town	01880		

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01880	Continued From page 50 and purchased items, and R4 always had a cough (Vicks). On June 24, 2025, at 12:05 p.m., CNS-C stated she was unaware R4 had Vicks Vapor Rub and Visine in her (R4's) room unsecured. CNS-C stated R4 goes out with her family (had the ability to purchase OTCs). CNS-C stated R4's medications, to include OTCs, were to be secured, and they were not.. RN-C stated she would seek orders for the OTCs found in R4's room. On June 24, 2025, at 1:02 p.m., the surveyor and RN-C went to R4's room RN-C removed the opened Vicks Vapor and unopened Visine from R4's room. RN-C stated these (eye drops and rub) should not be in R4's room unsecured. The licensee's Medication Storage policy dated March 3, 2025, noted medications would be stored consistent with each resident's medication management plan and service plan. Further, medication managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medications room, medications cart, or similar setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 51 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two residents (R4, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 23, 2025, at 10:54 a.m., the surveyor and registered nurse (RN)-C reviewed the contents of the locked medication cart. RN-C observed and confirmed the following: EXPIRATION DATE -one opened Lantus (long-acting insulin/diabetes) 100 units/milliliter (ml) pen for R4, included an open date of July 31, 2025, but lacked the insulin's expiration date. PRESCRIPTION LABEL R4's Lantus 100 units/ml pen was stored in a	01890		

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01890	Continued From page 52 baggie with a sticky note that noted R4's name. R4's Lantus lacked the original prescription label with legible information. Directly after the above observation RN-C stated R4 got her (R4) insulin from a "different" pharmacy. RN-C stated R4's Lantus required a pharmacy label with complete information noted. RN-C stated there was only one insulin pen used at the facility that she (RN-C) was aware of. RN-C stated they (nursing) monitored medications for expiration. RN-C stated she was not aware that medications required expiration dates. RN-C stated it made sense, why medication labels required expiration dates. The manufacturer's instructions for Lantus pens dated 2022, noted after 28 days throw your opened Lantus pen away, even if it still had insulin in it. R4 On June 24, 2025, at 7:26 a.m., the surveyor and unlicensed personnel (ULP)-H observed an opened Spiriva Respimat 2.5 micrograms (mcg) inhaler (chronic obstructive pulmonary disease /COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) for R4 in a medication basket undated. On June 24, 2025, at 10:04 a.m. the surveyor reviewed R4's Spiriva Respimat inhaler with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she thought R4's Spiriva was a PRN (as desired or as needed) medication. LALD/CNS-A stated it was "routine for her (LALD/CNS-A) to document just the open date on time sensitive medication. LALD/CNS-A confirmed R4's Spiriva lacked an open or an expiration date.	01890		

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01890	Continued From page 53 The manufacturer's instructions for Spiriva Respimat dated November 2021, noted write the discard by date on the label (three months from the date the cartridge was inserted). R3 On June 24, 2025, at approximately 10:05 a.m., R3's Novolog 100 units/ml insulin (short term insulin/ diabetes) pen was observed by LALD/CNS-A and the surveyor. LALD/CNS-A stated R3's Novolog pen was dated June 19, 2025. LALD/CNS-A stated that was the date R3's Novolog pen was opened. LALD/CNS-A stated she checked medications and discards medications when they expire. LALD/CNS-A stated she does not note an expiration date on time sensitive medications and added she knows she should include an expiration date on time sensitive medication. The manufacturer's instructions for Novolog dated January 2019, noted after 28 days, Novolog pens should be thrown away in the trash even it there was leftover insulin. The licensee's Medication Storage policy dated March 3, 2025, noted medication would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 54 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R7) who had treatments managed by the facility.	01940		

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01940	Continued From page 55 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 23, 2025, at 9:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment/therapy management services to the residents at the facility. R7's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), pneumonia, wheezing, anxiety, and pain. R7's service plan dated September 16, 2021, included: - assistance with dressing, two times daily and PRN (as needed or desired). R7's treatment administration record (TAR) dated June 1, 2025, through June 12, 2025, noted: - compression hose on in a.m., (morning) off at bedtime. R7's prescriber order dated April 24, 2025, included the above order. On June 24, 2025, at 6:31 a.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-F assist R7 to a standing position. The	01940		

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01940	Continued From page 56 surveyor observed a pair of compression hose on the floor near R7's recliner. ULP-F stated he had just applied a clean pair of compression hose to R7's legs. R7's service plan did not include a statement of the type of service that was provided to include: compression hose daily. On June 25, 2025, at 9:24 a.m., R7's service plan was reviewed with LALD/CNS-A. LALD/CNS-A stated she did not see compression hose on R7's service plan as required. The licensee's Treatment & Therapy Management Plan policy dated March 5, 2025, noted the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 57 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for three of four residents (R5, R7, R6) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R5 R5's diagnoses included Alzheimer's dementia. R5's service plan dated September 22, 2021, indicated R5 received the following services: - prepare modified diet, dated June 9, 2025, PRN	01950		

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01950	Continued From page 58 (as needed or desired) blend/grind food. On June 23, 2025, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-M use a food processor to prepare R5's noon meal. In addition, an unidentified person sat next to R5 and fed R5. On June 23, 2025, at 11:54 a.m., ULP-M stated the instructions for R5's diet should be in R5's record. On June 24, 2025, at 7:43 a.m., the surveyor observed ULP-M prepare R5's meal. ULP-M turned the food processor on, turned the food processor off, added milk to the mixture, and turned the food processor on again. On June 24, 2025, at 11:21 a.m., ULP-H stated R5 had been on a "grind diet" for a while now. R5's prescriber order dated June 9, 2025, noted, diet, regular: -blend/grind PRN (as desired or as needed). R5's undated Resident Care Plan noted: -PRN blend/grind food. R5's Monthly ADL (activities of daily living) record dated June 1, 2025, through June 23, 2025, noted: -appetite, ULP to note percentages of food consumed with breakfast, lunch, and dinner. R5's treatment administration record (TAR) dated June 1, 2025, through June 23, 2025, did not have any instructions for R5's diet. R5's record did not include complete written instructions for R5's modified diet.	01950		

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01950	Continued From page 59 On June 25, 2025, at 9:58 a.m., R5's record was reviewed with RN-C. RN-C stated R5's diet should be on R5's MAR/TAR. R5's MAR was reviewed, and RN-C stated R5's record did not include instruction for staff to modify R5's diet. R7 R7's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), pneumonia, wheezing, anxiety, and pain. R7's service plan dated September 16, 2021, included: -oxygen at 1-2 liters at night. R7's TAR dated June 1, 2025, through June 12, 2025, noted: -oxygen at two liters per nasal cannula (NC) at bedtime and PRN to keep saturations above 88% -monitor O2 (oxygen) saturation and apply PRN O2 if reading was below 88%. R7's prescriber order dated April 24, 2025, noted 1-2 liter per minute at nighttime O2 via NC. On June 24, 2025, at 6:31 a.m., the surveyor observed ULP-B and ULP-F assist R7 to a standing position. The surveyor observed two oxygen tanks in holders and an oxygen concentrator in R7's room. R7's record did not include complete written instructions for R7's oxygen use. On June 25, 2026, at 10:14 a.m., R7's record was reviewed with RN-C. RN-C stated R7's record should have noted to use PRN oxygen for signs and symptoms of shortness of breath (SOB).	01950		

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01950	Continued From page 60 RN-C confirmed R7's record lacked complete written instructions. R6 R6's diagnoses included traumatic brain injury (TBI-damage to the brain caused by an external force, such as a blow or jolt to the head. It can range from mile (like a concussion) to severe, affecting cognitive, physical, and psychosocial functions). R6's service plan dated September 15, 2021, included, hands-on assistance with transfers and mobility, manual tilt wheelchair (wheelchair that allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure), standing lift, every day and PRN (as needed or desired). On June 24, 2025, at 5:53 a.m., the surveyor observed ULP-E and ULP-G transfer R6 from a sit to stand (mechanical lift) into a tilt-n-space wheelchair. On June 24, 2025, at 5:58 a.m., ULP-E asked R6 if he was comfortable, are you leaning back far enough, do you want to lean back more? Do you want the footrests on? ULP-E used the controls on the wheelchair handles to tilt R6's chair. R6's assessment dated February 18, 2025, included: ambulation: -tilt back wheelchair (wheelchair that allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure) R6's record included: (R6's name) is appropriate to use his tilt back wheelchair. He requires this	01950		

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01950	Continued From page 61 chair for pressure relief, positioning, and comfort when completing his daily activities and interacting with his environment. The chair has been custom fit to (R6's) needs and will be appropriate for his use going forward, dated March 12, 2025, authenticated by OTR/L (occupational therapy professional). R6's Individual PCA (personal care attendant/unlicensed personnel (ULP) Care Plan dated June 2025, included: -wheeling, wheels self, assist (long distances). R6's record did not include complete written instructions for R6's tilt-n-space wheelchair as required. On June 24, 2025, at 11:56 a.m., R6's record was reviewed with RN-C. RN-C stated R6's record did not include specific directions for R6's tilt-n-space wheelchair. RN-C stated it made sense to have instructions in resident's records. RN-C added she had specific instructions for ULPs in resident's records to use sit-to-stand lifts or Hoyer lifts (mechanical lifts). RN-C stated resident records should have instructions for specialized wheelchairs. On June 25, 2025, at 10:31 a.m., RN-C stated there was another resident who used a tilt-n-space wheelchair and there were no instructions in that resident's record either. RN-C stated she had directions for compression hose (TEDs) and for catheter (narrow tube used to drain urine from the body) but she did not think about adding instructions for tilt-n-space wheelchairs. The licensee's Delegation of Assisted Living Services policy dated March 5, 2025, noted the	01950		

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01950	Continued From page 62 registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01960		

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01960	Continued From page 63 The findings include: R7's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), pneumonia, wheezing, anxiety, and pain. R7's service plan dated September 16, 2021, included: -oxygen at 1-2 liters at night. R7's treatment administration record (TAR) dated June 1, 2025, through June 12, 2025, noted: -oxygen at two liters per nasal cannula (NC) at bedtime and PRN (as desired or as needed) to keep saturations above 88%. -monitor O2 (oxygen) saturation and apply PRN oxygen if reading is below 88%. R7's prescriber order dated April 24, 2025, noted 1-2 liter per minute nighttime O2 via NC. On June 24, 2025, at 6:31 a.m., the surveyor observed ULP-B and ULP-F assist R7 to a standing position. The surveyor observed two oxygen tanks in holders and an oxygen concentrator in R7's room. On June 25, 2025, at 10:11 a.m., R7's record was reviewed with registered nurse (RN)-C. RN-C stated R7's record should have noted one or two liters of oxygen, and when to use one and when to use two liters. RN-C stated she would, should have sought clarification. RN-C stated a "doctor" (prescriber) changed R7's order and added some verbiage. RN-C stated some prescribers are very good at going through each item on orders and some or not.	01960		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 64 The licensee's Medication & Treatment Orders policy dated March 5, 2025, noted the licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. The license nurse would also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. A resident's MAR and TAR would be audited regularly by licensed nurse or designee for documenting compliance. The licensee's Medication & Treatment Orders-Implementing policy dated March 5, 2025, noted upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order with 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 65 health care and medical, or nursing standards for one of one resident (R6) with hospital-style bed rails. 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: R6's diagnoses included traumatic brain injury (TBI-damage to the brain caused by an external force, such as a blow or jolt to the head. It can range from mile (like a concussion) to severe, affecting cognitive, physical, and psychosocial functions). R6's service plan dated September 15, 2021, included, hands-on assistance with transfers and mobility, manual tilt wheelchair (allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure, standing lift, every day and PRN (as needed or desired). On June 24, 2025, at 5:53 a.m., the surveyor observed R6 in a hospital bed with an upper half hospital rail in the lowered position on the side of the bed R6 exited from. ULP-E and ULP-G transferred R6 with the aid of a sit to stand lift (mechanical lift) into a tilt-n-space wheelchair. R6's side rail (bed rails) assessment form dated January 12, 2025, included:	02310		

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02310	Continued From page 66 - is the resident non-ambulatory: yes - does the resident's level of consciousness fluctuate? no - does the resident have alteration in safety awareness due to cognitive (arrow up/arrow down)? no - does the resident have a history of falls? no - has the resident displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed? yes - does the resident have difficulty with balance or poor trunk control? yes - does the resident have difficulty with postural hypotension (low blood pressure)? no - is the resident on any medications which may require safety precaution? no - is the resident currently using the side rail for position or support? yes - has the resident expressed a desire to have side rails raised while in bed or safety and/or comfort? yes - has the resident requested that the side rails not be release while sleeping? yes - is the resident visually challenged? no interventions: - provide frequent staff monitoring at night - provide assisted toileting for the resident at night - staff rounds recommendations: right (side of bed) - side rails are indicated and serve as an enabler to promote independence - the resident has expressed a desire to have side rails raised while in bed. - see attached FDA (food and drug administration) sheet. R6's assessment dated May 15, 2025, noted: side rail/bed rail, full assist. R6's record included:	02310		

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02310	Continued From page 67 - side rail entrapment statistics, the benefits and risks of bed rails, and meeting patient's needs for safety documentation. R6's record lacked a comprehensive assessment on the use of an assistive device to include measurements. On June 25, 2025, at 9:09 a.m., R6's record was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she completed one main side rail assessment yearly. LALD/CNS-A added she "checks the box" every 90 days if bed rails were used. LALD/CNS-A stated she reviews the licensee's side rail policy regarding measurements; to check to see it side rails are within acceptable guidelines. LALD/CNS-A stated she did not document side rail measurements. LALD/CNS-A added in the past she looked at a side rail a family member brought in, she measured the side rails and told them no they could not use that side rail and the measurements did not meet their policies required measurements. LALD/CNS-A confirmed it was not the practice of the licensee to document bed rail measurements. The licensee's Side Rails policy dated March 5, 2025, noted, when side rails are in sue, an RN (registered nurse) must conduct an assessment to identify the intend purpose of the side rail and the risks regarding the use of the side rail. Side rail design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones one, two, and three, must not exceed 4.75 inches. The Guidance for Industry and FDA (Federal and	02310		

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02310	Continued From page 68 Drug Administration) Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, noted, reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment and monitoring, as well as meeting patient, resident, and family needs for vulnerable patients in most health care settings - hospitals, long term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending on the patient, FDA encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. FDA recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going	02310		

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02310	Continued From page 69 assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication administration process was completed as instructed by one of three 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, but was not likely to cause serious injury, impairment, or death), and	02320		

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02320	Continued From page 70 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 was hired on October 20, 2017, to provide direct care services to the facility's residents. On June 24, 2025, from 6:29 a.m., until 7:10 a.m., the surveyor continuously observed ULP-B. DOCUMENTATION PRIOR TO MEDICATION ADMINISTRATION On June 24, 2025, at 6:29 a.m., the surveyor observed ULP-B remove a DuoNeb 0.5-3 (2.5) milligram (mg)/3 milliliter (ml) nebulizer vial (pneumonia) (medication administered through a small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs) from R7's medication storage bin. ULP-B reviewed R7's medication administration record (MAR). ULP-B wrote her initials in R7's MAR for the DuoNeb (initials indicate medication was administered). ULP-B took the DuoNeb vial to R7's room where ULP-F was assisting R7. ULP-B and ULP-F assisted R7 into a chair. On June 24, at 6:36 a.m., ULP-B left R7's room. On June 24, 2025, at 6:38 a.m., ULP-B re-entered R7's room, and prepared R7's nebulizer. On June 24, 2025, at 6:39 a.m., ULP-B started R7's nebulizer machine. On June 24, 2025, at 6:47 a.m., ULP-B turned off	02320		

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02320	Continued From page 71 R7's nebulizer machine. ULP-B documented R7's DuoNeb nebulizer as administered prior to administration. On June 24, 2025, at 7:10 a.m., ULP-B stated she got nervous and should not have documented R7's DuoNeb prior to its administration. On June 24, 2024, at 12:12 p.m., registered nurse (RN)-C stated ULP-B was not trained to document medications prior to administration. RN-C stated she trained staff to dot the MAR when medications were prepared and to return to the MAR and document (initial) right after medication administration. DOCUMENTATION AFTER MEDICATION ADMINISTRATION On June 24, 2025, at 6:52 a.m., the surveyor observed ULP-B hand R7 a medication cup of prepared oral medications. On June 24, 2025, at 6:54 a.m., ULP-B completed R7's oral medication administration. On June 24, 2025, at 6:55 a.m., ULP-B went to the kitchen, and to the laundry room. ULP-B returned to R7's room, combed R7's hair, and assisted R7 with aid of a transfer belt ambulate to the dining area. On June 24, 2025, at 7:09 a.m., ULP-B got a glass of juice out of the refrigerator and took the juice to an unidentified resident's room. On June 24, 2025, at 7:10 a.m., ULP-B documented R7's oral medication as administered.	02320		

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02320	Continued From page 72 On June 24, 2025, at 11:24 a.m., RN-C stated ULP-B should have documented R7's oral medication administration "right away" (right after giving medication). RN-C stated ULP-B should not have done other things. RN-C added ULP-B could have forgotten to document R7's medication as administered. RN-C stated ULP-B went rogue (did own thing, did not administer medication as taught). The licensee's Nebulizer Treatment policy dated March 5, 2025, noted: -wash hands before touching any nebulizer equipment -place nebulizer on a flat surface -connect one end of the nebulizer tubing to the connector on the nebulizer box -assemble clean nebulizer parts -turn power switch on "on" to start treatment. A mist should begin to appear -mouthpiece should be placed between the teeth or facemask applied securely covering the nose and mouth -turn power switch to "off" when treatment is completed and mist has stopped document the nebulizer treatment. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided.	02320		

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02320	Continued From page 73 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719
St. Louis County
Parcel:

Phone:

License Info

License: HFID 30680

Risk:
License:
Expires on:
CFPM: Ayva Terzich
CFPM #: Pending; Exp:

Inspection Info

Report Number: F7983251007
Inspection Type: Full - Single
Date: 6/23/2025 Time: 10:00:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT:
OBSERVED LEFTOVERS IN THE FRIGIDAIRE COMMERCIAL SINGLE-DOOR UPRIGHT REFRIGERATOR IN HOUSE 1. THEY WERE DISCARDED.
Comply By: Complied On Site Originally Issued On: 6/23/2025

Food & Beverage General Comment

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Three separate facilities (houses 1, 2, and 3).

3) The warewashing machine in house 3 was inoperable at the time of inspection. Utensils were being cleaned and sanitized using three compartments and chlorine sanitizer. Observed chlorine sanitizer test strips.

4) Provided an temperature requirement fact sheet and a TCS food fact sheet.

==========

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F7983251007 from 6/23/2025

Charles Gargano

Gary Collyard,

Owner

Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Aspen Grove Assisted Living
Chisholm
County/Group: St. Louis County

Inspection Info

Report Number: F7983251007
Inspection Type: Full
Date: 6/23/2025
Time: 10:00:00 AM

Food Temperature: Product/Item/Unit: House 1: Frigidaire Commercial single-door upright refrigerator.**; Temperature Process:** Cold-Holding
Location: Milk at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 1: Frigidaire single-door upright freezer**; Temperature Process:** Cold-Holding
Location: All foods frozen solid at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 1: Holiday chest freezer-storeroom**; Temperature Process:** Cold-Holding
Location: All foods frozen solid at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 1: Kenmore single-door upright freezer-storeroom**; Temperature Process:** Cold-Holding
Location: All foods frozen solid at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 1: Arctic Air single-door upright refrigerator-storeroom**; Temperature Process:** Cold-Holding
Location: Raw shell egg at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 2: Aurora single-door upright refrigerator**; Temperature Process:** Cold-Holding
Location: Raw shell egg at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 3: Aurora single-door upright refrigerator**; Temperature Process:** Cold-Holding
Location: Raw shell egg at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: House 3: Element single-door upright freezer**; Temperature Process:** Cold-Holding
Location: All foods frozen solid at N/A Degrees F.
Comment:
Violation Issued?: No

<u>Equipment Temperature</u>: Product/Item/Unit: Utensil surface temperature**; Temperature Process:** Sanitizing
Location: Final rinse of the warewashing machine. at 155 Degrees F.
Comment: NSF residential unit.
Violation Issued?: No