DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2025

Licensee
Highland Path
1925 Norfolk Avenue
Saint Paul, MN 55116

RE: Project Number(s) SL32400016

Dear Licensee:

On November 10, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 28, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

CLN

Electronically Delivered

October 9, 2025

Licensee
Highland Path
1925 Norfolk Avenue
Saint Paul, MN 55116

RE: Project Number(s) SL32400016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

(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: SL #32400016-0 On August 25, 2025, through August 28, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 78 residents, 73 of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license. On August 28, 2025, an immediate correction order was issued for tag identification 2310 at a scope and level of G. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Liv-ing License Providers. The assigned tag number appears in the far left column entitled "ID Pre-fix Tag." The state Statute number and the corresponding text of the state Statute out of compli-ance 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 surveyors' 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 DEFI-CIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLA-TIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2025, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 3 Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 4 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure records included documentation of medication management services provided as identified in the service plan for one of six residents (R4). This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients/residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's service plan, dated July 10, 2025, indicated	0 730		

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0 730	Continued From page 5 R4 received services including medication management. On August 25, 2025, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-D assisting R4 to their apartment using verbal cueing. R4's medication administration record (MAR), dated August 2025, indicated R4 was on a leave of absence (LOA) from August 21, 2025, to August 24, 2025. On August 27, 2025, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated R4 had gone to their cabin for a LOA and medications would have been set up by the facility nurse for that time. CNS-B further stated a MAR, and a current medication list would have been given to the family to take with them and a form would have been signed by the family that they received education on medication administration. CNS-B stated he would look for the records. On August 28, 2028, at 10:01 a.m., via email, campus administrator (CA)-A provided the surveyor with a medication list print out, dated August 21, 2025, and stated the list had been given to R4's family. CA-A further stated the nurse who set up the medications was "out due to a family funeral," and they were not able to locate the form indicating the family received the medications and the written information regarding the medications, but they were confident the nurse had the form. The licensee's AL Leave of Absence Medication Policy revised June 6, 2023, indicated staff would document when medications were given to the	0 730		

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0 730	Continued From page 6 resident or resident's representative when the resident would be away from home and the registered nurse would review the documentation to verify that the procedures were followed, and the documentation was complete. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
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 August 26, 2025, from 9:30 a.m. to 11:30 a.m., with environmental service	0 775		

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0 775	Continued From page 7 director (ESD)-H and campus administrator (CA)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a controlled egress locking system installed on the emergency exit doors in the memory care unit leading to the exterior exit path. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors for building occupants to exit in the event of an emergency. The procedures required to operate and unlock the controlled egress locking system for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo	01610		

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01610	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for two of four residents (R3, R5) on or before the admission date. This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/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 clients/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:	01610		

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01610	Continued From page 9 R3 and R5 were admitted January 3, 2024, and April 28, 2025, respectively. R3's service plan, dated August 28, 2025, indicated R3 received services including bathroom and transferring assistance and medication administration. R5's service plan dated August 6, 2025, indicated R5 received services including medication administration. On August 25, 2025, at 1:15 p.m., unlicensed personnel (ULP)-D was observed assisting R3 with bathroom and transferring assistance. On August 26, 2025, at 7:40 a.m., ULP-G was observed assisting R5 with dressing and medication administration. R3 and R5's record contained an initial RN nursing assessment dated January 16, 2024, and April 30, 2025, respectively. R3 and R5's record lacked evidence of an RN assessment of the physical and cognitive needs of the resident, completed prior to contract signing or move in date. On August 27, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated they typically completed a functional assessment prior to the resident moving in, and the initial comprehensive assessment on move in day. CNS-B further stated he was not sure why R3 and R5's initial assessments were done late. CNS-B stated they had been covering two facilities on a "stretch assignment" during the time of R5's assessment	01610		

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01610	Continued From page 10 and that may have been why it was missed. The licensee's MN AL Nursing Assessments policy, updated May 3, 2022, indicated a registered nurse would conduct an assessment 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 community or the date on which a prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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	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 11 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for one of four residents (R3).	01620		

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	32400	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

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01620	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients/residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted January 3, 2024. R3's service plan, dated August 28, 2025, indicated R3 received services including bathroom and transferring assistance and medication administration. On August 25, 2025, at 1:15 p.m., unlicensed personnel (ULP)-D was observed assisting R3 with bathroom and transferring assistance. R3's record lacked a resident reassessment and monitoring, conducted no more than 14 calendar days after initiation of services. On August 27, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the 14-day reassessment had not been done for R3 and they were not sure why it had been missed. The licensee's MN AL Nursing Assessments policy, updated May 3, 2022, indicated the resident reassessment and monitoring would be conducted no more than 14 days after the initiation of assisted living services.	01620		

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01620	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days after the date services were first provided and include a	01640		

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01640	Continued From page 14 signature or other authentication by the facility and by the resident for two of five residents (R4, R7). This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients/residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 R4 was admitted March 3, 2025. On August 25, 2025, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-D assisting R4 to their apartment using verbal cueing. R4's record included a service plan, dated March 12, 2025, which indicated R4 received services including medication administration, and verbal cueing. The service plan was authenticated by R4's designated representative but lacked a signature or other authentication by a facility representative documenting agreement on the services to be provided. On August 27, 2025, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated R4's service plan was not signed by a facility representative and it "should have been signed by me." CNS-B further stated it was probably an oversite.	01640		

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01640	Continued From page 15 R7 R7 was admitted April 15, 2024. On August 25, 2025, at 12:20 p.m., R7 was observed eating lunch in the dining room. -at 12:45 p.m., unlicensed personnel ULP-D was observed assisting R7 with a cup of coffee and provided R7 with a tissue. R7's record included a signed service plan, dated October 19, 2024, which indicated R7 received services including medication administration. The record lacked a service plan finalized within 14 calendar days after services were first provided. On August 27, 2025, at 1:06 p.m., campus administrator (CA)-A stated they were unable to locate R7's initial service plan, and they were not sure why it was missing. The licensee's MN AL Service Plan policy dated August 1, 2021, indicated a finalized service plan would be completed no later than 14 days after initiation of services, and would include a signature or authentication by the licensee and by the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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01760	Continued From page 16 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriber orders for medications were correctly transcribed, for one of five residents (R5). This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients/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 service plan dated August 12, 2025, indicated R5 received services to include medication management and administration. On August 26, 2025, at 8:25 a.m., unlicensed personnel (ULP)-G was observed assisting R5 with morning medications.	01760		

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01760	Continued From page 17 A provider's order, as noted on the providers All Conversations: Medication Management form, dated June 24, 2025, indicated R5 was to receive acetaminophen (used for mild pain) 500 milligrams by mouth every six hours as needed. On August 27, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B identified the All Conversations: Medication Management form as current provider orders. CNS-B stated it looked like the acetaminophen had not been entered into R5's medication administration record and it was not ordered from the pharmacy. CNS-B further stated the medication should have been ordered to be available as needed and must have been an oversite. The licensee's AL Medication Management Policy dated June 25, 2025, indicated orders would be received and requested via telephone order, fax or clinical referral from a prescribing provider and new orders would be communicated to the pharmacy, resident assistant and resident or family. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered	01870		

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01870	Continued From page 18 nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have awareness of medications brought from home for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients/residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6's service plan dated January 15, 2025, indicated R6 received services including medication management and administration, storage of medication, and ongoing resident monitoring and reassessment. On August 26, 2025, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R6 with medication administration. On the counter below a locked medication storage cabinet in R6's kitchen, the surveyor observed one bottle of acetaminophen 500 milligrams (mg) strength and one bottle of acetaminophen 325 mg strength. R6's medication administration record (MAR), dated July 1, 2025, through August 28, 2025,	01870		

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01870	Continued From page 19 lacked an indication that R6 received acetaminophen. On August 26, 2025, at 8:25 a.m., ULP-G stated they did not administer acetaminophen to R6 and the medications "must be his." R6 stated he administered the acetaminophen to himself and had been taking it two to three times a day "since it's been smokey." A nursing assessment dated June 9, 2025, indicated R6 was unable to safely self-administer medications. On August 27, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated the licensee manages and administers all R6's medications and he should not be taking any on his own. CNS-B further stated his daughter must have brought the medication in. The licensee's AL Medication Management Policy dated June 25, 2025, indicated all medications would be stored in a locked box in a cabinet or refrigerator in the resident's unit. The policy further indicated the preferred method of medication administration was in prepackaged blister cards provided from the pharmacy and included over the counter medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 20 An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). Findings include: A record review and interview were conducted on August 26, 2025, at 10:45 a.m. with environmental service director (ESD)-H and	02040		

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02040	Continued From page 21 campus administrator (CA)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of three residents (R3) who utilized side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 25, 2025, at 1:15 p.m., with	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 22 unlicensed personnel (ULP)-D, the surveyor observed raised bilateral (both sides of the bed) consumer Halo side rails on R3's unoccupied hospital bed. R3's unsigned Service Plan - Attachment E to Residency Agreement dated August 28, 2025, indicated R3 received services including medication management and administration, bathroom assist, transfer assist, and escort. R3's nursing assessment dated July 3, 2025, did not include a side rail assessment. R3's medical record lacked documentation of the following: -a completed side rail assessment (completed on August 28, 2025, after initiation of the survey); -the risks and benefits were discussed with the resident/responsible party (completed on August 28, 2025, after initiation of the survey) -the portable side rail has not been recalled by the Consumer Product Safety Commission (CPSC); and -the portable side rail was installed, used, and maintained per manufacturer's guidelines. On August 28, 2025, at 11:12 a.m., campus administrator (CA)-A provide a bed rail assessment for R3 and stated the assessment had been completed August 28, 2025. On August 28, 2025, at 1:23 p.m., clinical nurse supervisor (CNS)-B, stated R3's bed rail assessment should have been done by the registered nurse when the bed rail was first installed, and it must have been an "oversite." The licensee's AL Physical Device policy revised	02310		

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02310	Continued From page 23 July 31, 2024, indicated the resident would be assessed for appropriate use of a bed rail device, the resident or resident representative would be educated on the risks and benefits, and the bed rail would be installed per the manufacturer's guidelines. The policy further indicated staff would document in the resident's clinical record at the implementation of the device or upon identification of the device by the facility staff. The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going 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." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an	02310		

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02310	Continued From page 24 improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HIGHLAND PATH
1925 NORFOLK AVENUE
St Paul, MN 55116
Hennepin County
Parcel:

Phone:

License Info

License: HFID 32400

Risk:
License:
Expires on:
CFPM: NINA-MARIE NAONE
CFPM #: 58030; Exp: 6/2/2028

Inspection Info

Report Number: F1023251094
Inspection Type: Full - Single
Date: 8/26/2025 Time: 10:55:21 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 2-400 Hygenic Practices
2-401.11B *Priority Level: Priority 3 CFP#: 6*
MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.
COMMENT: OBSERVED SPILLABLE CUP IN USE IN FOOD SERVICE AREA.
Comply By: 8/26/2025 Originally Issued On: 8/26/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: NO REMINDER SIGN AT MEMORY CARE HAND SINK.
Comply By: 8/26/2025 Originally Issued On: 8/26/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS COMMERCIAL EQUIPMENT IN A MAIN KITCHEN AREA AND MEMORY CARE SERVICE AREA. FOOD SERVICE IS PROVIDED BY CARE FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED EGGS REQUIRED FOR EGGS TO ORDER
- TIME AS A PUBLIC HEALTH CONTROL (SALAD STATION, DRINKS)

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 Metro District Office inspection report number F1023251094 from 8/26/2025

Gregory T Nelson

NINA-MARIE NAONE
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

HIGHLAND PATH
St Paul
County/Group: Hennepin County

Inspection Info

Report Number: F1023251094
Inspection Type: Full
Date: 8/26/2025
Time: 10:55:21 AM

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler #1 at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Upright Cooler #2 at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HAM**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SAUCE**; Temperature Process:** Hot-Holding
Location: Steam Table #1 at 144 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SOUP**; Temperature Process:** Hot-Holding
Location: Steam Table #2 at 165 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT TOMATO**; Temperature Process:** Time as Public Health Control
Location: On Ice at 42 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: JUICE**; Temperature Process:** Time as Public Health Control
Location: On Ice at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT FRUIT**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment: Memory care service area.
Violation Issued?: No

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St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

HIGHLAND PATH
St Paul
County/Group: Hennepin County

Inspection Info

Report Number: F1023251094
Inspection Type: Full
Date: 8/26/2025
Time: 10:55:21 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 175 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 700 PPM
Comment:
Violation Issued?: No