Electronically Delivered

May 5, 2026

Licensee
Rest Care Homes Inc
515 16th Avenue North
Saint Cloud, MN 56303

RE: Project Number(s) SL39554016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2026, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	39554	A. BUILDING: _____ B. WING _____	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOMES INC	515 16TH AVENUE NORTH SAINT CLOUD, MN 56303

(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: SL39554016-0 On April 7, 2026, through April 10, 2026, 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 was one resident; one resident receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow residents to choose the residents' visitors and times of visits. 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: R2 was admitted to the licensee on August 12, 2025, to receive assisted living services.	0 460		

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0 460	Continued From page 2 On April 7, 2026, at 10:50 a.m., the surveyor reviewed R2's assisted living contract dated August 12, 2025. A separate two-page form titled client self-responsibility and liability waiver was dated November 19, 2025. The two-page form indicated, "I agree to inform staff in advance of any visitors I plan to have at the residence. Failure to notify staff may result in documentation of non-compliance for record-keeping and safety monitoring". On April 8, 2026, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated the self-responsibility and liability waiver form had been created due to behavior and safety concerns staff had regarding R2. CNS-B confirmed the concerns were not included in her service plan. On April 9, 2026, at 11:07 a.m., licensed assisted living director (LALD)-C stated, "we know we can't prevent them from having visitors. We cannot put it that way I guess, but I wasn't fully aware we couldn't do that". The licensee's undated Bill of Rights policy indicated residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		

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0 480	Continued From page 3	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 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 5 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		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse 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	0 630		

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0 630	Continued From page 6 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: R2 was admitted to the licensee on August 12, 2025, to receive assisted living services. R2's individual abuse prevention plan (IAPP) lacked a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. On April 8, 2026, at 11:02 a.m. clinical nurse supervisor (CNS)-B stated he was aware of the IAPP requirements, and they must have missed checking the box in RTasks (electronic medical record). The licensee's undated Abuse Prevention Plan policy indicated that all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 7 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and a complete health history and symptom screening for one of two employees, (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 660		

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0 660	Continued From page 8 On April 8, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-B provided a facility risk assessment dated 2023. CNS-B stated licensed assisted living director (LALD)-C was responsible for completing it. ULP-E began employment on January 23, 2026, to provide direct care services. ULP-E's employee record contained a document titled Baseline TB Screening Tool for Health Care Worker's (HCWs) dated January 20, 2026. ULP-E failed to complete the employee history section. On April 9, 2026, at 11:09 a.m., LALD-C stated, "the nurse does that, I just review and make sure they are done". The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer having direct contact with residents must have documentation of a baseline health symptom screening prior to providing care to residents. This includes a health and symptom screen. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." "An employee may begin working with patients after a	0 660		

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0 660	Continued From page 9 negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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.	0 810		

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0 810	Continued From page 10 (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 8,2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		

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01060	Continued From page 11	01060		
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 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	01060		

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01060	Continued From page 12 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 interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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) 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: R2 was admitted to the licensee on August 12, 2025, to receive assisted living services. R2's record indicated R2 was hospitalized on November 24, 2025, through November 29, 2025, for cardiac arrhythmia and elevated blood pressure. In addition, R2 was hospitalized on January 9, 2026, through January 20, 2025, for shortness of breath and fluid overload. R2's record lacked a written notice provided to R2 including: - the name and contact information for the location to which the resident has been relocated	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39554	A. BUILDING: _____ B. WING _____	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOMES INC	515 16TH AVENUE NORTH SAINT CLOUD, MN 56303

(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
01060	Continued From page 13 and any new service provider - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities - 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 - 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. -notify Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On April 8, 2026, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated he was not aware that needed to be done and he had not completed the required emergency relocation notifications for any resident. A policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 14 least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the	01530		

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01530	Continued From page 15 licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for one employee, (unlicensed personnel (ULP)-E). This had the potential to affect all residents and staff. 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: ULP-E began employment on January 23, 2026, to provide direct care services. ULP-E's employee record lacked the required initial two hours in mental illness and de-escalation training. On April 9, 2026, at 11:10 a.m., licensed assisted living director (LALD)-C stated she was not aware that mental health training was required. LALD-C stated, "I guess we need to do it now". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01720 SS=F	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment	01720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01720	Continued From page 16 for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for 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) 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: R2 was admitted to the licensee on August 12, 2025, to receive assisted living services. R2's diagnoses included bipolar disorder, generalized anxiety disorder, attention deficit hyperactivity disorder, unspecified atrial fibrillation, and hypertension. R2's unsigned Service Plan dated August 21, 2025, indicated R2 received medication reminders and monitoring. R2's Medication Management Plan dated March 28, 2026, indicated R2's medications were administered by staff three (3) times per day.	01720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39554	A. BUILDING: _____ B. WING _____	04/10/2026

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01720	Continued From page 17 R2's Medication Administration Records (MAR) dated March 1, 2026, through March 31, 2026, and April 1, 2026, through April 7, 2026, indicated R2 received the following medications: -aripiprazole (bipolar) 10 milligrams (mg) daily -buproprion hydrochloride (depression) 150 mg daily -digoxin (heart failure) 125 micrograms (mcg) daily -Doxycyclate Hyclate (infection) 100 mg twice daily -Eliquis (blood clots) 5 mg twice daily -ferrous sulfate (supplement) 325 mg every other day -lamotrigine (bipolar) 100 mg daily -metoprolol (blood pressure) 50 mg twice daily -pantoprazole (gastric reflux) 40 mg twice daily -torsemide (diuretic)10 mg twice daily plus an additional 10 mg if weight goes up 3 pounds in a day, or 5 pounds in a week -vitamin B12 (supplement)1000 mcg daily (Ends on March 24, 2026) -women multivitamins (supplement)1 tab daily The following medications were circled in red on the March 2026 MAR indicating medication was declined or skipped: - torsemide was not given 17 of 31 days. The reasons included, "she doesn't want", "she declined", "notify or talk to the nurse", "the resident didn't need to take her medication because it's going to make her go to the bathroom", "refused", "client refused scheduled medication when offered. Staff provided encouragement. nurse notified", "medication not given", "resident didn't want to take the medication", and "I give the resident her medications". - metoprolol was not given 25 of 31 days. The	01720		

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01720	Continued From page 18 reasons included, "I give the resident her medications on time", "needs refill", and "the medication is done". The following medication was circled in red on the April 2026 MAR indicating medication was declined or skipped: - torsemide was not given 4 of 7 days. The reasons included, "she doesn't want", "she declined", "notify or talk to the nurse". R1's progress notes dated March 1, 2026, through April 8, 2026, included one entry on March 14, 2026, regarding R2 not taking scheduled medications. Entry stated, "Refused despite staff encouragement. Medication was not administered. The nurse was informed". On April 7, 2025, at 12:15 p.m., unlicensed personnel (ULP)-D indicated the staff administer R2's medications in RTasks (electronic medical record). He stated R2's medications are stored in a locked cabinet in the basement. On April 7, 2026, at 2:45 p.m., R2 indicated she doesn't like to take her water pill because it makes her urinate too much and does refuse her medications at times. On September 8, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated he is aware that R2 frequently refuses medications. He stated he had provided education to R2 and staff, on multiple occasions, regarding the importance of taking her medications. CNS-B stated R2's medical record lacked documentation indicating the issue was being addressed. The licensee's undated Medication Management Services policy indicated based on the nursing	01720		

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01720	Continued From page 19 assessment, the RN will develop an individualized medication management plan for each resident receiving any type of medication management services. The RN will develop, and update as needed specific procedures for the following medication management activities: -documentation of communications with the prescriber, pharmacist, resident, and resident's representative, if any, and education of residents about their medications -verify that prescriptions drugs are administered as prescribed -the RN or LPN will review each resident's medication record when the nurse is setting up medications and at other appropriate times based on the resident's needs and resident's medication management services, including during the resident monitoring visit to verify that staff is administering the medication as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title. Any issues or concerns will require follow-up and documentation by the nurse, including communications with the prescriber and pharmacy, education of the resident and/or the resident's representative, and additional training for staff or other appropriate actions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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01910	Continued From page 20 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one resident, R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01910		

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01910	Continued From page 21 R1 discharged from licensee on December 11, 2023. R1's service plan indicated R1 received medication management services. R1's record lacked evidence of documentation of R1's disposition of medications to include a prescription number for oxycodone 5 milligrams (mg). On April 8, 2026, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated he did not add the prescription number, he was not aware that it was required for all discharged residents. The licensee's undated Medication Disposition or Disposal policy indicated controlled substances require staff to document the release of the controlled drug medication, listing the date, medication name, quantity, strength, and dosage form of the medications; prescription number, name, address and telephone number of the dispensing pharmacy; name and signature of the person releasing the drug; and name and signature of the person receiving the controlled drug upon discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Rest Care Homes Inc
515 16TH AVENUE NORTH
St Cloud, MN 56303
Stearns County
Parcel:

Phone:

License Info

License: HFID 39554

Risk:
License:
Expires on:
CFPM: Thomasia Evelyn Naya
CFPM #: 58283; Exp: 4/28/2028

Inspection Info

Report Number: F1046261087
Inspection Type: Full - Single
Date: 4/7/2026 Time: 12:15:36 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: OBTAIN EITHER A MAX-REGISTERING THERMOMETER FOR THE DISHWASHER, OR OBTAIN THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. THERMOLABELS LEFT ONSITE.
Comply By: 4/21/2026 Originally Issued On: 4/7/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: DISHWASHER CURRENTLY HAS A SIGN POSTED ON IT SAYING "OUT OF ORDER". OPERATOR HAS ORDERED A NEW DISHWASHER TO HAVE INSTALLED. USE 2 COMP SINK METHOD FOR SANITIZING UNTIL DISHWASHER IS REPAIRED/REPLACED.
Comply By: 4/21/2026 Originally Issued On: 4/7/2026

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: OBSERVED A SPRAY BOTTLE IN THE CABINET WITH NO LABEL. LABEL ALL CONTAINERS WITH CONTENTS.
Comply By: 4/7/2026 Originally Issued On: 4/7/2026

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 St Cloud District Office inspection report number F1046261087 from 4/7/2026

_____ _____

Establishment Representative

Nicole Larrison,
Public Health Sanitarian 1
320-640-3534
nicole.larrison@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Rest Care Homes Inc
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046261087
Inspection Type: Full
Date: 4/7/2026
Time: 12:15:36 PM

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

Minnesota (MDH) Version
EH Manager; RPT: F1046261087

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	0	Date: 4/7/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:15:36 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Rest Care Homes Inc	515 16TH AVENUE NORTH	St Cloud, MN	56303	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 39554		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R
COS=corrected on-site during inspection **R**=repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39554016-0	**Date:** 4/8/2026
Facility Name: REST CARE HOMES INC	
Facility Address: 515 16TH AVENUE NORTH ST. CLOUD, MN 56303	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: clinical nurse supervisor (CNS)-B stated the resident training took place during the evacuation drill. No documentation was provided indicating trainings took place.

3. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Review of the evacuation log indicated the overnight and evening shifts completed the drills during a combined evacuation drill. Evacuation drills shall be completed on each shift.