



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 1, 2026

Licensee
Pierz Meadow Ponds Inc
305 Ronald Avenue
Pierz, MN 56364

RE: Project Number(s) SL30431016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 16, 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 . . ."

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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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.

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,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30431	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2026
NAME OF PROVIDER OR SUPPLIER PIERZ MEADOW PONDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 RONALD AVENUE PIERZ, MN 56364		
(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: SL30431016-0 On September 14, 2026, through September 16, 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 were 16 resident(s); 16 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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, 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 September 15, 2026, for the specific Minnesota Food Code violations. The	0 480			

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0 480	Continued From page 3 Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during medication administration for one of two employees (unlicensed personnel (ULP)-G). 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	0 510			

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0 510	Continued From page 4 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 14, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A and regional register nurse (RRN)-B stated the licensee provided required infection control training upon hire and at a minimum, annually. ULP-G was hired on December 22, 2025, to provide direct assisted living services to the licensee's residents. ULP-G's employee record indicated ULP-G completed infection control and medication administration on January 21, 2026. On September 14, 2026, at 3:25 p.m., through 3:35 p.m., the surveyor observed ULP-G wearing gloves, prepare R7's medications, enter R7's room, administer R7's medications, exited the room and documented medications administered in EMR (electronic medical record). ULP-G prepared R8's medications, entered R8's room, administered medications, exited room and documented medications administered in EMR. The surveyor did not observe ULP-G change gloves or perform hand hygiene prior to preparing resident medications, in between administering resident medications or after administering medications. Immediately following the medication observations, ULP-G stated ULP-G realized ULP-G should have changed gloves and performed hand hygiene after administering each resident's medications. On September 15, 2026, at 2:43 p.m., RRN-B	0 510			

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0 510	Continued From page 5 stated ULP-G approached RNN-B later that same day and stated ULP-G forgot to change gloves in between administering resident medications. RRN-B stated it was not required for staff to wear gloves for medication administration; however, if gloves were worn, staff should change gloves between residents and perform hand hygiene when gloves were removed. The licensee's Hand Washing policy dated May 27, 2025, indicated hand hygiene should be performed before and after administering medications to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	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 observation, interview, and record review, the licensee failed to ensure an individual	0 630			

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0 630	Continued From page 6 abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A and regional register nurse (RRN)-B stated the licensee was familiar with the current minimum assisted living requirements. R3's diagnoses included atrial fibrillation, prediabetes, cognitive decline, and generalized weakness. R3's Service Plan (Waiver) dated June 1, 2026, indicated R3's services included medication administration, bathing, assistance with CPAP (continuous positive airway pressure) machine, compression stockings, leg brace, behavior monitoring, housekeeping and laundry. On September 15, 2026, at 6:17 a.m., the surveyor observed unlicensed personnel (ULP)-F administering R3's scheduled medications. R3's IAPP dated August 11, 2026, indicated R3 was not at risk of abusing other vulnerable adults and had no history of risk of self-abuse; however,	0 630			

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0 630	Continued From page 7 R3's IAPP did not include an assessment of R3's risk to be abused by others. On September 16, 2026, at 8:42 a.m., RRN-B stated RRN-B was aware of the required content in an IAPP assessment. RRN-B reviewed R3's IAPP and stated RRN-B was unsure why R3's IAPP was missing the review of R3's risk of abuse by others and would have to look into it further. The licensee's Individual Abuse Prevention Plan policy dated September 10, 2025, indicated the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult. The IAPP would include; -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 -statement of specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650			

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0 650	Continued From page 8 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A and regional register nurse	0 650			

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0 650	Continued From page 9 (RRN)-B stated the licensee was familiar with the current minimum assisted living requirements. ULP-G was hired on December 22, 2025, to provide direct assisted living services to the licensee's residents. On September 14, 2026, at 3:25 p.m., the surveyor observed ULP-G administering R7 and R8's scheduled medications. ULP-G's record included training transcripts indicating ULP-G was assigned and completed required training; however, lacked evidence ULP-G demonstrated competencies to the registered nurse before provide assisted living services in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other registered nurse (RN)/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On September 16, 2026, at 11:57 a.m., LALD-A stated LALD-A was unable to locate ULP-G's competency evaluation records. LALD-A stated	0 650			

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0 650	Continued From page 10 ULP-G was trained by RRN-B and for some reason, the previous administrator did not scan ULP-G's training records into Residex (cloud-based Electronic Health Record (EHR). On September 16, 2026, at 12:06 p.m., RNN-B stated RNN-B and licensed practical nurse (LPN)-D completed ULP-G's training and competencies with ULP-G and completed ULP-G's orientation checklist; however, ULP-G's documents were not scanned into Residex. The licensee's Competency Training Evaluations policy dated June 23, 2025, indicated when a registered nurse (RN) or licensed health professional personnel delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel (ULP) is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. A copy of all education, training, and competency testing shall be kept in each team member's personnel file. The licensee's Training Records policy dated June 23, 2025, indicated the site (licensee) would maintain a record of personnel training and competency required which documents information for each competency evaluation, training, and orientation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 730 SS=E	144G.43 Subd. 3 Contents of resident record	0 730			

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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
0 730	Continued From page 11 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 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	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30431	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2026
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0 730	Continued From page 12 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 14, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A and regional register nurse (RRN)-B stated the licensee was familiar with the current minimum assisted living requirements. R2 R2's diagnoses included osteoarthritis and diabetes type II. R2's Service Plan (Waiver) dated July 2, 2026, indicated R2's services included medication	0 730			

Minnesota Department of Health

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0 730	Continued From page 13 management, bathing, meal assistance, meal attendance, blood glucose monitoring, safety checks, housekeeping and laundry services. On September 15, 2026, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F administering R2's scheduled medications. R2's Med Admin Summary on August 13, 2026, and September 8, 2026, indicated R2 was scheduled to receive acetaminophen 500 milligrams (mg) two tables at 1:00 p.m.; however, did not include staff initials indicating R2 received medication as scheduled. R2's August 2026 Service Recap Summary indicated R2 was scheduled to receive the following services; however, did not include staff initials indicating R2 received the following scheduled services: -laundry services August 4; -peri care at 5: p.m., on August 1, 8, 9, 12; -weight August 6; -encourage fluids August 6; -safety checks August 6; -meal attendance August 4, 6, 11, 14, 18, 22, 24, 26, 27, 28, 31; and -monthly blood glucose supervision August 17. R2's September 2026 Service Recap Summary indicated R2 was scheduled to receive the following services; however, did not include staff initials indicating R2 received the following scheduled services: -laundry services September 4, 8, 11; -safety checks August 15 at 10: p.m.; -behavior management September 15 (overnight); and -meal attendance September 1, 2, 4, 8, 10, 11, 12, and 15.	0 730			

Minnesota Department of Health

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0 730	Continued From page 14 R2's record lacked documentation of the administration of R2's acetaminophen, or the reason why the medication was not administered. In addition, R2's record lacked documentation of the services noted above, or the reason why the services were not provided to R2. R3 R3's diagnoses included atrial fibrillation, prediabetes, cognitive decline, and generalized weakness. R3's Service Plan (Waiver) dated June 1, 2026, indicated R3's services included medication administration, bathing, assistance with CPAP (continuous positive airway pressure) machine, compression stockings, leg brace, behavior monitoring, meal attendance, meal assistance, safety checks, housekeeping and laundry. On September 15, 2026, at 6:17 a.m., the surveyor observed ULP-F administering R3's scheduled medications. R3's August 2026 Service Recap Summary indicated R3 was scheduled to receive the following services; however, did not include staff initials indicating R3 received the following scheduled services: -skin care August 12, 18; -behavior management-demanding and depression August 13, 19; -meal attendance August 4, 6, 11, 14, 18, 22, 24, 26, 27, 28, 31; and -monthly supervision of leg brace August 15. R3's record lacked documentation of the services noted above, or the reason why the services were not provided to R3 as scheduled.	0 730			

Minnesota Department of Health

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0 730	Continued From page 15 On September 15, 2026, at 2:43 p.m., RRN-B stated ULPs were expected to document in the resident's electronic medication or treatment record right after a medication was administered or a scheduled service was provided and there should be no areas left blank. LALD-A stated the licensee would re-educate staff to ensure all services provided were documented or the reason why the service was not provided in the resident record. LALD-A further stated LALD-A would look into putting a "stop" in Residex (cloud-based Electronic Heath Record) that would not allow the staff to move to the next resident task until staff signed off on all medications and services administered. The licensee's Medication and Treatment Administration and Delegation policy dated August 11, 2025, indicated the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. The licensee's Medication Management: Administration and Setup policy dated March 20, 2026, indicated the following: -ULPs would chart in each resident's medication administration record any problems with medication administration, including refusals; -ULPs would document any 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	0 730			

Minnesota Department of Health

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0 730	Continued From page 16 with the resident's medication management plan; and -If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=E	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, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 775			

Minnesota Department of Health

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0 775	Continued From page 17 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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 an isolated scope (when one or a limited number of residents are affected or one or	0 800			

Minnesota Department of Health

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0 800	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

Minnesota Department of Health

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0 810	Continued From page 19 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810			

Minnesota Department of Health

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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

Page: 1

Establishment Info

PIERZ MEADOW PONDS INC
305 Ronald Ave
Pierz, MN 56364
Morrison County
Parcel:

Phone:
manager@pierzmeadowponds.com

License Info

License: HFID 30431
Samantha Adams
Risk:
License:
Expires on:
CFPM: Katherine DeRosier
CFPM #: ; Exp: 10/14/2027

Inspection Info

Report Number: F6808261109
Inspection Type: Full - Single
Date: 9/15/2026 Time: 12:10:32 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! New Order: 3-800 Highly Susceptible Population

3-801.11B *Priority Level: Priority 1 CFP#: 26*

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages and except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined, when serving a highly susceptible population.

COMMENT: USE PASTEURIZED EGGS FOR PREPARATION OF EGGS TO ORDER (OVER EASY OR OVER MEDIUM).

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

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: POST SIGNS IN RESTROOMS USED BY EMPLOYEES.

Comply By: 9/17/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

DISCUSSED:

NOT STORING WATER PITCHERS AND ICE SCOOPS ON AN ABSORBENT MAT. STORE ON A NONABSORBENT SURFACE. MAT WAS CHANGED OUT TO PLASTIC TRAYS.

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 F6808261109 from 9/15/2026

Lee Ann Austin

Establishment Representative

Lee Ann Austin,
Public Health Sanitarian 3
320-223-7341
lee.ann.austin@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

PIERZ MEADOW PONDS INC
Pierz
County/Group: Morrison County

Inspection Info

Report Number: F6808261109
Inspection Type: Full
Date: 9/15/2026
Time: 12:10:32 PM

Food Temperature: **Product/Item/Unit:** HB EGGS; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
PIERZ MEADOW PONDS INC	Report Number: F6808261109
Pierz	Inspection Type: Full
County/Group: Morrison County	Date: 9/15/2026
	Time: 12:10:32 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 163 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30431016-0	Date: September 15, 2026
Facility Name: Pierz Meadow Ponds Inc	
Facility Address: 305 Ronald Avenue, Pierz, MN 56364	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: There was a single station plug in carbon monoxide detector installed in the mechanical room and two carbon monoxide detectors installed in the corridor. A carbon monoxide detection system was not installed in all rooms that contained fuel-burning appliances and carbon monoxide alarms were not installed within ten feet of all bedrooms.

3. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments:

- The one hour labeled fire door between the kitchen and dining room did not fully close and positively latch.*
- The labeled fire doors for the public restroom and resident room 103 were held open with kick down door stops.*

Fire doors shall be maintained to close and latch automatically after every use, preventing the spread of smoke and fire in the event of an emergency.

4. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: Smoking materials were inappropriately disposed of inside a flowerpot in the designated smoking area.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

- *The ceiling surface was peeling above the shower in the bathroom of resident room 114.*
- *The cover for the panic bar was missing on the interior door at the main entrance.*

☒ **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 licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building, third party templates were used.

- *The procedures inaccurately referenced smoke compartment doors and fire doors on magnetic door holders. Smoke zones were referenced but not identified.*
- *Employees were inaccurately directed to fire panels above the ice machine in the kitchen and on the wall above the front desk.*

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested evacuation procedures for the individualized unique needs of residents from the licensee. The provided emergency binder included resident evacuation reports, dated February 10, 2026. These reports assigned each resident an evacuation assistance level, but the specific evacuation procedures were lacking. Additionally, these procedures were not kept with the fire safety and evacuation plan and there were no instructions within the FSEP on where these procedures were maintained.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments:

- *The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the last year, from the licensee. Documentation was provided indicating employees were offered FSEP training on April 29, 2026, during a staff meeting. Attendance records with employee names were not maintained for this training, information needed to evaluate regulatory compliance.*
- *The surveyor requested records for employee FSEP training completed at the time of hire from the licensee. Record review of the provided documentation indicated employees completed online training on emergency preparedness from a third party at the time of hire. The licensee stated new hire employees were trained on the site specific FSEP, but records had not been created to document this. Employee training on the FSEP was not completed at the required frequency.*

4. 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: The surveyor requested records for resident training on fire safety and evacuation completed in the last year from the licensee. Documentation was provided indicating residents were offered emergency procedures training on January 28, 2026, during a resident council meeting. Records were not maintained that included a list of residents who attended this training, information needed to evaluate regulatory compliance. Additionally, the emergency procedures training did not list fire safety and evacuation on the agenda.