



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 3, 2026

Licensee
Harmony View Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL33426017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2026
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NAME OF PROVIDER OR SUPPLIER HARMONEY VIEW ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 2ND STREET NORTH SAUK RAPIDS, MN 56379
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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
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL33426017-0</p> <p>On March 10, 2026, through March 12, 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 22 residents: 19 receiving services under the Assisted Living Facility license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 650 SS=F	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of</p>	0 650		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 650	<p>Continued From page 1</p> <p>each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <ul style="list-style-type: none"> (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency 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. <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee, (unlicensed personnel (ULP)-D).</p> <p>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).</p>	0 650		

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0 650	<p>Continued From page 2</p> <p>The findings include:</p> <p>ULP-D began employment on January 17, 2022, to provide direct care services to residents.</p> <p>ULP-D's employee record lacked documentation of a current annual performance review that identified areas of improvement needed and training needs.</p> <p>On March 11, 2026, at 2:01 p.m., housing manager (HM)-E stated ULP-D did not have a performance review. She stated they are aware of the requirement but have not completed performance reviews for any staff.</p> <p>The licensee's Supervision of Unlicensed Personnel policy dated January 3, 2023, indicated the clinical nurse supervisor (CNS) or designee is responsible for completing a performance review of each staff person providing assisted living services, based on the documentation of the supervisor's observations and other relevant information.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by:</p>	0 775		

Minnesota Department of Health

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0 775	<p>Continued From page 3</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-10-26, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days.</p>	0 775		
0 790 SS=C	<p>144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p>	0 790		

Minnesota Department of Health

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0 790	<p>Continued From page 4</p> <p>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.</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-10-26, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days</p>	0 790		
0 800 SS=A	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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</p>	0 800		

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0 800	<p>Continued From page 5</p> <p>residents in accordance with a maintenance and repair program.</p> <p>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.</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-10-26, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	0 800		
0 810 SS=I	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 6</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>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.</p> <p>This practice resulted in a level three violation (a</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 7</p> <p>violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-10-26, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Twnty One (21) Days</p>	0 810		
01530 SS=D	<p>144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-</p> <p>(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 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</p>	01530		

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01530	<p>Continued From page 8</p> <p>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;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide two hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for one of one employee, (clinical nurse supervisor (CNS)-B).</p> <p>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</p>	01530		

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01530	<p>Continued From page 9</p> <p>situation has occurred only occasionally).</p> <p>The findings include:</p> <p>CNS-B began employment on July 16, 2025, to provide direct care services and supervision of staff.</p> <p>CNS-B's employee record lacked two hours of initial training on mental illness and de-escalation topics.</p> <p>On March 11, 2026, at 1:57 p.m., housing manager (HM)-E stated it was an oversight, and the required training had not been assigned to CNS-B in Educare (online training program).</p> <p>A policy was requested but not received.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01530		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for</p>	01640		

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01640	<p>Continued From page 10</p> <p>Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a written service plan within 14 calendar days for one of one resident (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted to licensee's assisted living facility on December 2, 2025, and began receiving assisted living services.</p> <p>R2's Service Plan (Waiver)- Addendum to Contract, dated December 23, 2025, was signed by R2 on December 30, 2025. The service plan indicated R2 received services which included vital sign monitoring, medication administration and set-up, support stockings, oxygen</p>	01640		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2026
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NAME OF PROVIDER OR SUPPLIER HARMONEY VIEW ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 2ND STREET NORTH SAUK RAPIDS, MN 56379
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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
01640	<p>Continued From page 11</p> <p>assistance, meal reminders, bathing assistance, well-being checks, and housekeeping.</p> <p>R2's current signed service plan dated December 30, 2025, was the only service plan completed since date of admission on December 2, 2025.</p> <p>On March 11, 2026, at 11:42 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was responsible for completing the service plans, however she had not completed the initial or the 14-day service plans as required. CNS-B stated it was an oversight.</p> <p>The licensee's Contents of Service Plans policy dated January 3, 2023, indicated all assisted living residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN) and/or other licensed health professional. Furthermore, a proposed service plan would be established after completion of an individualized, initial assessment, and a finalized service plan would be completed no later than 14 calendar days after initiation of services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01890 SS=F	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2026
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NAME OF PROVIDER OR SUPPLIER HARMONEY VIEW ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 2ND STREET NORTH SAUK RAPIDS, MN 56379
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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
01890	<p>Continued From page 12</p> <p>drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for two of two residents (R2, R6) and to keep a medication in its original container bearing the original prescription label for one of one resident (R2). In addition, the licensee failed to discard expired medication for one of one resident (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On March 10, 2026, at 2:05 p.m., the surveyor and unlicensed personnel (ULP)-C and ULP-D reviewed the contents of the locked medication cart and medication fridge and found the following:</p> <ul style="list-style-type: none"> -R2's Arnuity Ellipta (asthma) 200 micrograms (mcg) lacked a prescription label and an opened or expiration date. -R5's acetaminophen extended release (pain) 500 milligram (mg) expired on January 21, 2025. -R6's Symbicort (asthma) 160 - 4.5 mcg/actuation inhaler lacked an opened or expiration date. <p>On March 11, at 2:14 p.m., ULP-C stated he had</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2026
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NAME OF PROVIDER OR SUPPLIER HARMONEY VIEW ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 2ND STREET NORTH SAUK RAPIDS, MN 56379
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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
01890	<p>Continued From page 13</p> <p>been trained to write the open date on all medications.</p> <p>On March 11, at 2:20 p.m., ULP-D stated ULP's are trained to write open and expiration dates on all time sensitive medications.</p> <p>On March 11, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated she trains ULP's to indicate the open and expiration dates on times sensitive medications and to keep the original containers. She stated she is responsible for removing expired medications from the medication cart, and that she must have overlooked R5's expired medication.</p> <p>The manufacturer's guidelines for Arnuity Ellipta inhaler revised January 2019, indicated to discard ARNUITY ELLIPTA 6 weeks after opening the tray or when the counter reads "0", whichever comes first.</p> <p>The manufacturer's guidelines for Symbicort inhaler revised January 2017 indicated to throw away SYMBICORT when the counter reaches Zero ("0") or 3 months after you take it out of its foil pouch, whichever comes first.</p> <p>The licensee's Storage of Medications policy, dated January 3, 2023, indicated medications will be handled and stored per acceptable standards.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		



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

Harmony View Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379
Benton County
Parcel:

Phone:

License Info

License: HFID 39135

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1046261059
Inspection Type: Full - Single
Date: 3/10/2026 Time: 1:30:04 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSED TAGGING THE ANSUL AND FIRE EXTINGUISHERS (EXPIRES END OF MAY 2026), SANITIZER TYPES AND CONCENTRATIONS, NOROVIRUS AND KEEPING ILL EMPLOYEES AT HOME, AND IDENTIFYING UNSAFE CANNED GOODS.

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 F1046261059 from 3/10/2026

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

Page: 1

Establishment Info

Harmony View Assisted Living
Sauk Rapids
County/Group: Benton County

Inspection Info

Report Number: F1046261059
Inspection Type: Full
Date: 3/10/2026
Time: 1:30:04 PM

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

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED HAM; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 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

Harmony View Assisted Living
Sauk Rapids
County/Group: Benton County

Inspection Info

Report Number: F1046261059
Inspection Type: Full
Date: 3/10/2026
Time: 1:30:04 PM

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

Location: Dishwashing Area **Equal To** 160.7 Degrees F.

Comment:

Violation Issued?: No

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: 3/10/2026
	No. of Repeat Risk Factor/Intervention/Violations		Time: 1:30:04 PM
	Score (optional)		Dur: min
Establishment: Harmony View Assisted Living	Address: 1420 2nd Street North	City/State: Sauk Rapids, MN	Zip: 56379
License/Permit #: HFID 39135	Permit Holder:	Purpose of Inspection: Full	Est. Type: Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item		Mark "X" in appropriate box for COS and/or R	
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable		COS=corrected on-site during inspection R=repeat violation	

Compliance Status	COS	R	Description
Supervision			
1	IN		Person in charge present, demonstrate knowledge and performs duties
2	IN		Certified Food Protection Manager
Employee Health			
3	IN		knowledge, responsibilities, 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	Description
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	N/A		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

Compliance Status	COS	R	Description
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

Compliance Status	COS	R	Description
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			Food & non-food contact surfaces cleanable, properly designed, constructed, & used
48			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:
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Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33426017-0	Date: 3/10/2026
Facility Name: HARMONEY VIEW ASSISTED LIVING	
Facility Address: 1420 2ND STREET NORTH SAUK RAPIDS, MN 56379	

TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) 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. 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: Fire-rated doors throughout the facility were held open with permanent door stops. This included resident rooms and staff areas.

TAG IDENTIFICATION: 0790

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The required monthly inspections were not documented.

TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 1; 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 light fixture at the first level on the north stairway was missing its protective shroud.

TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 3; 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. 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: House Manager (HM)-E stated a policy for unique and unusual needs had not been created.

3. 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: HM-E stated there was not a program in place for resident training.

4. 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 drill log indicated only the overnight shift had completed drills in 2025 and 2026.