Electronically Delivered

June 2, 2026

Licensee
Pheasants Ridge
1807 Sunrise Drive
Saint Peter, MN 56082

RE: Project Number(s) SL30532016

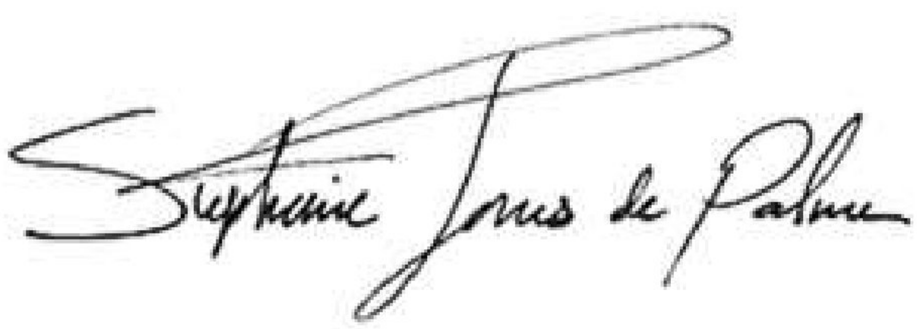
Dear Licensee:

On October 6, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 17, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Health Regulation Division
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320
Fax: 1-866-890-9290

JMD

Electronically Delivered

May 22, 2025

Licensee
Pheasants Ridge
1807 Sunrise Drive
Saint Peter, MN 56082

RE: Project Number(s) SL30532016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

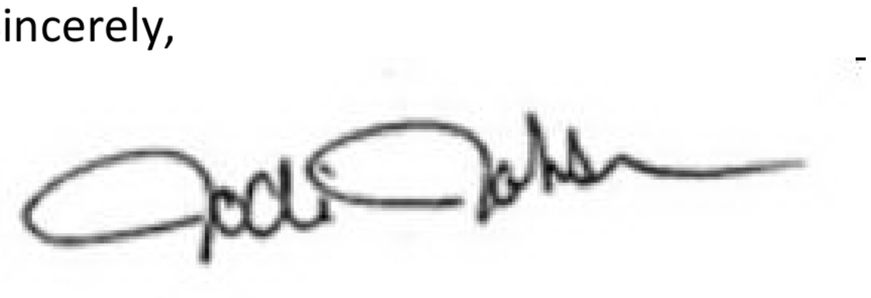
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30532	A. BUILDING: _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANTS RIDGE	1807 SUNRISE DRIVE SAINT PETER, MN 56082

(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 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: SL30532016-0 On April 14, 2025, through April 17, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 1 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on April 15, 2025, from 9:31 a.m. through 10:41 a.m., with licensed assisted living director (LALD)-G, the surveyor observed the following: The inspection tag on the fire sprinkler riser was dated 2/13/2023. The surveyor asked LALD-G if there was a more recent sprinkler inspection. LALD-G made a phone call during the tour. After the phone call LALD-G stated that was last time the sprinkler system had been inspected. LALD-G stated they thought the facility was on an annual inspection schedule, but the phone call confirmed it was not. LALD-G stated they would have the sprinkler inspected and get on the schedule for annual inspections. State Fire Code in Minnesota Rules, chapter 7511 requires fire sprinkler systems be inspected at least annually.	0 775		

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0 775	Continued From page 2 Twenty-minute fire-resistant rated doors to the salon, and the laundry room had spring hinges designed to close the door. The door did not self-close and latch as designed. The latch was removed from the salon door. Fire-resistant rated doors must automatically close and latch to prevent the spread of smoke and fire to adjoining building areas. LALD-G stated they understood the requirement and would have the doors adjusted or repaired. The rear exit door in the memory care wing opened into a fenced area that had a locked gate. LALD-G stated the gate lock was not connected to the building fire alarms and would not unlock when the fire alarms activated. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. Carbon monoxide alarms were not provided in the resident rooms within ten feet of every sleeping room, or the mechanical rooms. State Fire Code in Minnesota Rules, chapter 7511 requires either; rooms that contain a fuel burning appliance be equipped with a carbon monoxide detection system, or carbon monoxide alarms be located within ten feet of every sleeping room. LALD-G verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 3 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During facility tour on April 15, 2025, from 9:31 a.m. through 10:41 a.m., with licensed assisted living director (LALD)-G, the surveyor observed portable fire extinguishers located on a shelf in cabinets in the assisted living and memory care wings. The extinguishers were not mounted in conspicuous and unobstructed locations as required by State Fire Code in Minnesota Rules, chapter 7511.	0 790		

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0 790	Continued From page 4 The surveyor observed that there was no other portable fire extinguishers located in the facility. During the tour the surveyor and LALD-G measured the distance from the fire extinguisher in the assisted living wing to the end of the corridor by resident room 103. The measurement was more than 100 feet. Portable fire extinguishers are required to be provided in locations so that travel distance to the nearest fire extinguisher does not exceed 75 feet. LALD-G verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	01060		

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01060	Continued From page 5 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 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 the 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	01060		

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01060	Continued From page 6 or has the potential to affect a large portion or all the residents). The findings include: R2's start of care was November 12, 2024, with diagnoses including vascular dementia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and history of stroke. R2's 14-Day (Corrected) Care Plan (service plan) dated March 11, 2025, indicated R2 received services including behavior management, medication administration, assistance with bathing, dressing, transfers, compression stockings, escorts to meals, housekeeping, and laundry. R2's provider note dated March 24, 2025, indicated R2 had been hospitalized from December 24, 2024, to December 31, 2024, due to a fall resulting with a right hip fracture. On December 31, 2024, R2 was admitted to a skilled nursing facility, was discharged on March 11, 2024, and returned to the licensee. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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	01060		

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01060	Continued From page 7 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. On April 16, 205, at 8:47 a.m., licensed assisted living director (LALD)-A stated they contact the family and case manager (if applicable) of an emergency relocation; although they had not been providing a written notice with the required content. LALD-A further stated if the resident did not return within four days, the licensee was not informing the ombudsman of an emergency relocation and providing a written notice because they were unaware of the requirement. The licensee's Contract Termination policy, reviewed October 8, 2024, indicated: 8. Emergency relocation 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 will provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 8 (6) The notice required will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative; b) for residents who receive home and community-based waiver services under the resident's case manager; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

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01440	Continued From page 9 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (ULP-D, ULP-E) performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired April 5, 2024, to provide direct care services. On April 15, 2025, at 11:37 a.m., the surveyor observed ULP-D administering insulin to R4. ULP-D's employee record did not include a 30-day direct supervisory review. ULP-E ULP-E was hired September 23, 2023, to provide direct care services.	01440		

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01440	Continued From page 10 On April 15, 2025, at 11:08 a.m., the surveyor observed ULP-E apply compression stockings and Velcro wraps to R4's lower legs bilaterally. ULP-E's employee record did not include a 30-day direct supervisory review. On April 16, 2025, at 12:43 p.m., director of human resources (DHR)-C stated being unable to locate evidence a 30-day supervision of a delegated task had been completed by a registered nurse for ULP-D or ULP-E. The licensee's Attachment D - Individual Service Plan form provided to all residents indicated: All staff providing services will be supervised by RN within 30 days of employment and periodically thereafter, not to exceed annually. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 11 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 12 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired September 23, 2023, to provide direct care services. On April 15, 2025, at 11:08 a.m., the surveyor observed ULP-E apply compression stockings and Velcro wraps to R4's lower legs bilaterally. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Infection control techniques On April 16, 2025, at 1:44 p.m., director of human resources (DHR)-C reviewed ULP-E's employee record and stated the above training had not	01500		

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01500	Continued From page 13 been completed every 12 months as required. The licensee's Annual Training Assisted Living With Memory Care policy reviewed October 8, 2024, indicated: 1. All assisted living employees will complete annual education on the following topics: d. Infection control techniques used in the home and implementation of infection control standards including i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01540		

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01540	Continued From page 14 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two direct care employees (unlicensed personal (ULP)-E) received the required two hours of annual dementia training for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired September 23, 2023, to provide direct care services. ULP-E's employee record lacked evidence of completing two hours of dementia training for each 12 months of employment prior to the start of the survey. On April 16, 2025, at 1:44 p.m., director of human resources (DHR)-C reviewed ULP-E's employee record and stated the annual dementia training	01540		

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01540	Continued From page 15 had not been completed every 12 months as required. The licensee's Dementia Training Assisted Living With Memory Care policy reviewed October 8, 2024, indicated: Direct-care employees will have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620		

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01620	Continued From page 16 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive change of condition assessment following hospitalization for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2's start of care was November 12, 2024, with diagnoses including vascular dementia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and history of stroke. R2's 14-Day (Corrected) Care Plan (service plan) dated March 11, 2025, indicated R2 received services including behavior management, medication administration, assistance with bathing, dressing, transfers, compression stockings, escorts to meals, housekeeping, and laundry. R2's provider note dated March 24, 2025, indicated R2 had been hospitalized from December 24, 2024, to December 31, 2024, due to a fall which resulted in a right hip fracture. On	01620		

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01620	Continued From page 17 December 31, 2024, R2 was admitted to a skilled nursing facility (SNF), was discharged on March 11, 2024, and returned to the licensee. All of R2's RN assessments were requested. Assessments provided were dated October 22, 2024, November 17, 2024, November 26, 2024, and March 18, 2025. R2's record did not include a change of condition assessment by the RN upon return from the hospital. On April 17, 2025, at 9:55 a.m., clinical nurse supervisor (CNS)-B stated she did not complete an assessment on the day R2 returned to the licensee; although she did update R2's care plan/service plan according to the services being received from the SNF. CNS-B further stated she had completed the change of condition assessment on March 18, 2025 (seven days later). The licensee's Initial and On-Going Nursing Assessment of Residents policy reviewed October 8, 2024, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

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01620	Continued From page 18 (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include	01700		

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01700	Continued From page 19 all required content for one of one newly admitted resident (R2), prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 14, 2025, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to many of the residents receiving assisted living services. R2's start of care was November 12, 2024, with diagnoses including atrial fibrillation, chronic obstructive pulmonary disease (COPD), hypertension (high blood pressure), gastroesophageal reflux disease (GERD-heartburn), hyperlipidemia (high cholesterol), and history of stroke. R2's 14-Day (Corrected) Care Plan (service plan) dated March 11, 2025, indicated R2 received services including behavior management, medication administration, assistance with bathing, dressing, transfers, compression stockings, escorts to meals, housekeeping, and laundry. R2's medication administration record (MAR) dated November 2024, included the following	01700		

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01700	Continued From page 20 medications: one bronchodialator (to treat COPD), one corticosteroid (to treat COPD), one antihyperlipidemic, one anticoagulant (blood thinner), one diuretic (water pill), one proton pump inhibitor (to treat GERD), and three supplements. The MAR indicated R2 began receiving medication administration services on the day of admission (November 12, 2024). R2's pre-admission assessment dated October 22, 2024, did not include a medication assessment with all the required components. R2 began receiving services from the licensee on November 12, 2024. R2's record indicated a medication management assessment was completed on November 17, 2024 (five days after start of services). On April 16, 2025, at 3:13 p.m., clinical nurse supervisor (CNS)-B R2's stated R2's pre-admission assessment was comprehensive and determined whether the resident needed medication management services; although it did not include all the required content. CNS-B stated her process for new admissions was to wait until the resident settled in for a few days to get to know them, then complete the admission assessment which included the comprehensive medication assessment. The licensee's Initial and Ongoing Nursing Assessments of Residents policy reviewed October 8, 2024, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to	01700		

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01700	Continued From page 21 14-days after start of services c. Ongoing assessment: Completed periodically but no less than every 90-days d. Change in resident condition 3. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the RN, and if the RN is aware of these records. Comprehensive assessment includes: d. Physical health status, including: v. Medication review including OTC (over the counter) medications, prescription medications and supplements including: 1. Reason taken 2. Side effects, contraindications, allergic or adverse reactions 3. Actions to address side effects, contraindications, allergic or adverse reactions 4. Dosage 5. Frequency of use 6. Route administered 7. Resident difficulties taking medications 8. Self-administration versus other type of administration 9. Resident preferences for taking medications 10. Medications management interventions to prevent drug diversion by the resident or others who have access to medications 11. Instructions to the resident and resident's legal/designated representative on interventions to manage the resident's medications and prevent medication diversion No further information was provided.	01700		

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01700	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	01790		

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01790	Continued From page 23 (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R5) who requested medications for an unplanned leave of absence. 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	01790		

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01790	Continued From page 24 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5's diagnoses included bipolar disorder. R5's 90 Day Care Plan (service plan) dated February 4, 2025, indicated R5 received services including medication administration, behavior monitoring, housekeeping, and laundry. R5's medication administration record (MAR) dated March 2025, indicated "OF" (out of facility) for medications administered from the evening of March 7-9, 2025, and March 26-30, 2025. The MAR did not indicate if the medications had been sent with R5 while out of the facility. On April 17, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated R5 had gone on a leave of absence (LOA) in March 2025, with a family member and R5's medications had been sent with the resident. CNS-B stated they set up each medication in a separate envelope and write on the envelope the name and dosage of the medication and the time it is to be taken and any other instructions if applicable; they don't require the resident or family member sign receiving the medications. CNS-B reviewed R5's March 2025, MAR for the LOA medications sent with the resident, and it indicated "OF" (out of facility). CNS-B was unable to find evidence in R5's record that the medications had been set up for administration and sent with the resident or her family member, along with signatures of who set up the medications, and who received them. CNS-B reviewed the licensee's policy on medications to be given when time away from home and stated the procedure staff were	01790		

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01790	Continued From page 25 completing was not the same as the policy. The licensee's Delegation of Medications to be Given to Clients by Unlicensed Staff for Time Away From Home policy, reviewed October 8, 2024, indicated: 1. Contact the RN on-call upon notification by client or family of plans to be absent during medication administration times to seek directions. (Special instructions may include the need for the RN to talk to the resident or resident's representative, instructions for storage, or for controlled substances.) 2. Review the MAR (Medication Administration Record) to determine the medications that will need to be sent with the client. 3. Obtain medications that will be needed for the planned LOA. 4. Obtain the agency 'package of forms' needed to accompany the medications. (Examples may include: Cover letter from RN with contact information, a current copy of the medications to be taken during the LOA in a manner the client or client's representative can understand. 5. Document the medications given in format required by agency by medication, dose, quantity and name of individual to whom the medications was given. 6. Request signature from client and/or client's representative signature to attest receipt of information on agency specific form. 7. Upon return the assisted living facility, obtain unused or refused medications from the client or client's representative. 8. Document the name and quantity of medication returned upon agency approved form or EMR (electronic medication record). 9. If medications are given to unlicensed personnel, unlicensed staff will notify the RN of the medications returned. RN sill instruct	01790		

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01790	Continued From page 26 unlicensed personnel on storage and security of unused medications and any other additional instructions. No returned medications will be administered without RN instructions. 10. If there are any questions of medications or concerns on the LOA procedure, the unlicensed staff will call the on-call RN for further instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for one of one resident (R4) who received insulin during medication administration. 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	01890		

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01890	Continued From page 27 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: R4's diagnoses included type II diabetes mellitus. R4's provider orders dated March 24, 2025, included an order for Humalog KwikPen 100 unit/ml (units per milliliter) subcutaneous (SQ) solution pen-injector. Inject 30 units SQ with breakfast; inject 48 units SQ with lunch; inject 35 units SQ with supper. On April 15, 2025, at 11:37 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R4's Humalog insulin pen for administration. The surveyor noted the prescription label on the pen indicated: Inject 30 units under the skin with breakfast. The insulin pen did not include instructions for the lunch and supper dosage. The surveyor asked ULP-D if they utilized the same Humalog insulin pen for all scheduled doses until a new pen is obtained; ULP-D responded, "yes". On April 17, 2025, at 10:06 a.m., clinical nurse supervisor (CNS)-B observed R4's open Humalog insulin pen in the medication cart with the surveyor. CNS-B reviewed the pharmacy label on the insulin pen and stated it did not include the entire order and should have. The licensee's Storage of Medications policy reviewed October 8, 2024, indicted: 8. Proper Storage of Medications b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container,	01890		

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01890	Continued From page 28 bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	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 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:	01910		

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01910	Continued From page 29 Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's dosage strength, for one of one discharged resident (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: The discharge resident roster provided by the licensee indicated R3 was admitted on September 8, 2023, and discharged on January 30, 2025, to a skilled nursing facility. R3's Care Plan (service plan) dated December 15, 2024, indicated R3 received services including medication administration. R3's Medical Waste Disposal Log dated February 5, 2025, indicated medications had been disposed of/destroyed at the police department. The document identified the medication name, quantity, prescription number, and signature of the licensee's staff that counted the medications and the person receiving the medications for destruction. The document did not include the prescription dosage strength for any of the identified medications including stool softener, furosemide (diuretic-water pill), Klor-Con (potassium supplement), and duloxetine	01910		

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01910	Continued From page 30 (antidepressant). On April 15, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B reviewed R3's Medical Waste Disposal Log and stated the dosage of each medication was not included as required. The licensee's Disposition or Disposal of Medication policy reviewed October 8, 2024, indicated: 3. Disposal of Unused or Discontinued Prescription Drugs Managed by our Agency c. Documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the client's record for two years. The licensee's policy did not include documentation of the dosage/strength of the medication upon destruction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 31 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01940		

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01940	Continued From page 32 The findings include: During the entrance conference on April 14, 2025, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the licensee's residents. R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD), lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues, primarily affecting the arms or legs), and heart disease. R1's Care Plan (service plan) dated January 23, 2025, indicated services included assistance with applying and removing thrombo-embolic deterrent (TED) stockings (compression stockings that reduce swelling and increase circulation in the lower extremities) and wraps daily. R1's Medication Administration Record (MAR) dated April 2025, included the following treatment orders. - Apply compression stockings and Velcro wraps BID (twice a day). Apply compression stocking and Velcro wraps, in the morning and take off if resident sleeps in bed, otherwise, do not take off. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R2 R2's diagnoses included vascular dementia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and history of stroke.	01940		

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01940	Continued From page 33 R2's 14-Day (Corrected) Care Plan (service plan) dated March 11, 2025, indicated R2 received services including assistance with compression stockings. R2's Medication Administration Record (MAR) dated April 2025, included the following treatment orders. - Compression stockings BID. Assist with putting on compression stockings in the AM and removing at HS (bedtime). Every night wash with mild detergent, rinse well, wrap in dry towel and gently wring out, then hang to dry overnight. R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On April 16, 2025, at 3:13 p.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's record and stated the records did not include direction to unlicensed staff on when to contact a nurse with issues for R1's compression stocking and Velcro wraps or R2's compression stockings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950		

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01950	Continued From page 34 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-D, ULP-E) demonstrated competency in Velcro wraps and compression pumps to a RN. 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 April 14, 2025, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment	01950		

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01950	Continued From page 35 management services to the licensee's residents. ULP-D ULP-D was hired April 5, 2024, to provide direct care services. ULP-E ULP-E was hired September 23, 2023, to provide direct care services. On April 15, 2025, at 11:08 a.m., the surveyor observed ULP-E applying compression stockings and Velcro compression wraps to R4's lower legs bilaterally. ULP-D and ULP-E's employee record lacked competencies for Velcro compression wraps and compression leg pumps. On April 16, 2025, at 1:44 p.m., director of human resources (DHR)-C stated they were unable to find evidence in ULP-D or ULP-E employee record of competency training/testing by an RN for compression Velcro wraps and compression leg pumps. On April 16, 2025, at 3:13 p.m., CNS-B stated ULPs had been trained on how to apply the compression Velcro wraps and compression leg pumps, but she did not document the training. The licensee's Delegation of Nursing Tasks policy reviewed October 8, 2024, indicated: 1. A Registered Nurse may delegate nursing services, or an authorized Licensed Health Professional may delegate treatments or assign therapy tasks, to unlicensed personnel that: a. have successfully completed the training required for unlicensed personnel, b. have been trained in the services to be	01950		

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01950	Continued From page 36 provided, c. have demonstrated to the RN or the Licensed Health Professional the ability to competently follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 37 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 15, 2025, at 10:42 a.m., licensed assisted living director (LALD)-G provided a document titled, Kaiser Permanente Emergency Management Summary for Pheasants Ridge Assisted Living and Memory Care, dated 2024. The document lacked a hazard vulnerability assessment with mitigation factors for the physical environment on and around property. During an interview on April 15, 2025, at 11:15 a.m., LALD-G verified that the licensee was not able to provide documentation of a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills;	02170		

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02170	Continued From page 38 (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R2) who received services in the secured memory care unit.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30532	A. BUILDING: _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANTS RIDGE	1807 SUNRISE DRIVE SAINT PETER, MN 56082

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02170	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license effective July 1, 2024. R2's start of care was November 12, 2024, with diagnoses including vascular dementia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and history of stroke. R2 resided in the secure memory care unit. R2's 14-Day (Corrected) Care Plan (service plan) dated March 11, 2025, indicated R2 received services including behavior management, medication administration, assistance with bathing, dressing, transfers, compression stockings, escorts to meals, housekeeping, and laundry. The care plan further indicated the care team will offer social activities throughout the day. Refer to activity calendar for scheduled event. Care team will attempt to redirect inappropriate behavior deterring from the activity. R2's Return from Hospital assessment (change of condition) dated March 18, 2025, did not include an assessment specific to activities. R2's record lacked evidence that the resident had been evaluated for activities according to the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30532	A. BUILDING: _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 40 licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. On April 17, 2025, at 9:24 a.m., licensed assisted living director (LALD)-A stated the activity director did not perform an activity assessment for the residents in the secured memory care unit. LALD-A stated the nurse will ask a few questions upon admission related to what they like to do for activities, which is incorporated into the care plan. LALD-A reviewed the statute criteria and stated R2's nursing assessment did not include all required components related to activities and the care plan was not individualized. The licensee's undated, ALDC Activities policy indicated: 1. Each resident receiving assisted living services will be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 2. To further facilitate person-centered care, social history information, information about the person's life history, will be gathered to assist in planning, information gathered may include	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30532	A. BUILDING: _____ B. WING _____	04/17/2025

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02170	Continued From page 41 information such as: a. places lived b. education, work, and military service history c. cultural and religious background d. family and other significant relationships 3. This information will be shared with staff as they are oriented to the individual. 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Dept. of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza
Mankato, MN

Type: Full
Date: *04/16/25*
Time: 12:05:29
Report: 1028251044

Food and Beverage Establishment Inspection Report

Location:

Pheasants Ridge
1807 Sunrise Drive
St Peter, MN56082
Nicollet County, 52

Establishment Info:

ID #: 0038447
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079310966
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 190 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Turbo Air - Ambient
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

This Inspection was conducted in conjunction with HRD.

Type: Full
Date: *04/16/25*
Time: 12:05:29
Report: 1028251044
Pheasants Ridge

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028251044 of 04/16/25.

Certified Food Protection Manager: Molly Rudenick

Certification Number: FM115347 Expires: 02/08/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Molly Rudenick

Signed: Ryan Miller
Ryan Miller
Environmental Health Specialist
MDH - Mankato
507-995-7672
Ryan.Miller@state.mn.us