



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 30, 2026

Licensee

1 On 1 Comprehensive Healthcare Solution LLC
3309 Kady Avenue Northeast
Saint Michael, MN 55376

RE: Project Number(s) SL41086015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 2, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER 1 ON 1 COMPREHENSIVE HEALTHCARE SOLL			STREET ADDRESS, CITY, STATE, ZIP CODE 3309 KADY AVENUE NORTHEAST SAINT MICHAEL, MN 55376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41086015-0 On June 1, 2026, through June 2, 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 five residents; all of whom were receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content 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 was admitted and began receiving assisted living services on October 1, 2025. R2's record included an assisted living contract signed by R2 on October 1, 2025. R2's record lacked an individualized review or assessment of the resident's risk of abusing other	0 630			

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0 630	Continued From page 2 vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On June 2, 2026, at 9:39 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C indicated the one question had been missed during completion and stated, "That is an oversight on my part." The licensee's Vulnerable Adult policy, dated March 21, 2026, indicated the licensee would ensure an assessment would be completed for vulnerability status of each resident upon admission, and would assess susceptibility to physical, verbal, sexual, financial exploitation abuse, and self-abuse, as well as the resident's risk of abusing other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	0 700			

Minnesota Department of Health

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0 700	Continued From page 3 Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R2 and R3) personal health and medical information was kept private. 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: On June 2, 2026, from 8:55 a.m. to 9:15 a.m., surveyor observed the unlicensed personnel (ULP)-D walk away from the charting computer to attend to other tasks in another area of the facility. The computer screen was left open displaying R2's medical information. The surveyor observed one resident and one staff that was not responsible for medications, seated in an open and accessible common area. On June 2, 2026, from 9:20 a.m. to 9:26 a.m., surveyor observed the unlicensed personnel (ULP)-D walk away from the charting computer to attend to other tasks in another area of the facility. The computer screen was left open displaying R3's medical information. The surveyor observed one resident and one staff that was not responsible for medications, seated in an open and accessible common area. On June 2, 2026, at 9:27 a.m., ULP-D stated, "I always close the screen when I walk away, I think I just forgot to today."	0 700			

Minnesota Department of Health

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0 700	Continued From page 4 On June 2, 2026, at 9:51 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "You should never leave it open, you should always close your screens." The licensee's Resident Confidentiality policy, dated March 21, 2026, indicated all resident information, including but not limited to personal, financial and medical data, would be kept confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=C	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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).	0 775			

Minnesota Department of Health

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0 775	Continued From page 5 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 780 SS=C	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

Minnesota Department of Health

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 810 SS=C	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

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0 810	Continued From page 7 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 810			

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0 810	Continued From page 8 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for all five residents. 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	01880			

Minnesota Department of Health

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01880	Continued From page 9 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: On June 1, 2026, at 7:39 a.m., the surveyor observed unlicensed personnel (ULP)-D pull a lanyard with a key attatched to it out of an unlocked kitchen drawer and unlock the medication closet and then return the key to the unlocked drawer. ULP-D obtained R3's medications, and went to R3's room leaving the medication cabinet unlocked. ULP-D returned to the unsecured medication closet and locked the door. There were four other residents in the facility. On June 2, 2026, from 8:55 a.m., through 9:26 a.m., the surveyor observed ULP-D pull a lanyard with a key attatched to it out of an unlocked kitchen drawer and unlock the medication closet. ULP-D obtained R2's medications, and went to R2's room leaving the medication cabinet unlocked. ULP-D returned to the unsecured medication closet and obtained R4's medication and closed the medication closet leaving it unlocked and went to R4's room. ULP-D then returned to the unlocked medication closet and pulled out R3's medications and placed the container on the kitchen island and closed the medication closet door leaving it unlocked. ULP-D obtained R3's medications and then leaving the medications on the counter went to R3's room. ULP-D then returned to the kitchen and put the medications away and locked the medication closet door. There were three other residents in the facility. On June 2, 2026, at 9:27 a.m., ULP-D stated,	01880			

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01880	Continued From page 10 "We always keep the door locked and the keys on us. I just forgot but otherwise the keys are on us, but when we are walking around doing things we keep them in the drawer." On June 2, 2026, at 9:51 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "It (medication closet) should be locked at all times if you are not watching the medications or another staff is watching the medications, they should keep them locked." The licensee's Storage/Control of Medications policy, dated March 21, 2026, indicated all prescription drugs would be securely locked in substantially constructed compartments according to the manufacturer's directions and only authorized personnel have access to the stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or 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	01910			

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01910	Continued From page 11 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication's prescription number as applicable in the disposition for one of one discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and began receiving services on March 16, 2025. R1 discharged to another facility on April 17, 2025. R1's record lacked a medication disposition to	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER 1 ON 1 COMPREHENSIVE HEALTHCARE SOLL			STREET ADDRESS, CITY, STATE, ZIP CODE 3309 KADY AVENUE NORTHEAST SAINT MICHAEL, MN 55376		
(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	
01910	Continued From page 12 include the medication's prescription number as applicable. On June 1, 2026, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "I think I have that on the reside form, I didn't know how to use it when he discharged, it puts in the prescription number for all the controlled substances but not for all the medications but going forward we need it for all the medications. We can do that." The Licensee's Disposition and Disposal or Medications policy, dated March 21, 2026, indicated, "Upon disposition, [Licensee] will document in the clinical record: (a) name, strength, and prescription number of medication; (b) quantity; (c) method of disposition or to whom the medications were given; (d) date of disposition; and (e) names and signatures of staff or other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

1 ON 1 COMPREHENSIVE HEALTHCARE
3309 KADY AVENUE NORTHEAST
St Michael, MN 55376
Wright County
Parcel:

Phone:

License Info

License: HFID 41086

Risk:
License:
Expires on:
CFPM: Karlu Dorleh
CFPM #: 17603; Exp: 11/17/2028

Inspection Info

Report Number: F1051261148
Inspection Type: Full - Single
Date: 6/1/2026 Time: 11:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, TESA BROWN.

DISCUSSED THE FOLLOWING WITH THE FOOD SERVICE DIRECTOR, KARLU:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS

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 F1051261148 from 6/1/2026

Karlu Dorleh
Food Service Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@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

1 ON 1 COMPREHENSIVE HEALTHCAR
St Michael
County/Group: Wright County

Inspection Info

Report Number: F1051261148
Inspection Type: Full
Date: 6/1/2026
Time: 11:30:00 AM

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41086015-0	Date: 6/2/2026
Facility Name: 1 ON 1 COMPREHENSIVE HEALTHCARE	
Facility Address: 3309 KADY AVENUE NORTHEAST; ST MICHAEL, MN 55376	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The evacuation map indicated an exit path from the assisted living area through the rear living room door, which leads to an enclosed patio. The map also showed exit routes through Resident Room 4 and through the garage. The evacuation path shall not indicate egress through the garage during a fire or similar emergency, as the garage is classified as a higher-hazard area than the assisted living environment.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: Durning tour of the facility licensed assisted living director (LALD)-C tested the smoke alarms. The facility was running two separate systems that did not interconnect with each other. Both systems provide appropriate coverage. LALD-C removed battery only smoke alarms while surveyor was on site. Facility now uses the hardwire smoke alarm system that is interconnected.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to maintain their FSEP as readily available. The licensee provided multiple policies for the surveyor to review. LALD-C indicated which policy they train on and use in the event of a fire. The policy should be cleaned up and organized so that only relevant policies and procedures are included to avoid confusion for staff and residents.