Electronically Delivered

August 13, 2026

Licensee
Elysian Senior Home of Northfield
2501 Jefferson Road
Northfield, MN 55057

RE: Project Number(s) SL34667017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 29, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $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.

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34667	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOME OF NORTHFIELD	2501 JEFFERSON ROAD NORTHFIELD, MN 55057

(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: SL34667017-0 On July 27, 2026, through July 29, 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 12 residents; 12 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of an assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living 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) 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: On July 27, 2026, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated ALD/CNS-A had a Residency Permit Director effective May 27, 2025, through May 26, 2026. On July 27, 2026, at 5:38 a.m., the evaluator emailed a BELTSS representative to clarify ALD/CNS-A's status as LALD for the facility. On July 28, 2026, at 12:27 p.m., the BELTSS representative stated "[ALD/CNS-A's name] is	0 110		

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0 110	Continued From page 2 very close to being licensed, just missing a few minor documents" and that ALD/CNS-A was called and emailed to update her on what was needed to become licensed. During the entrance conference on July 27, 2026, at approximately 9:30 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A stated she was the LALD for the licensee. On July 28, 2026, at 9:21 a.m., ALD/CNS-A stated she became licensed after completing and passing the exam in April 2026. ALD/CNS-A reviewed the BELTSS website and stated she did not know that she needed to update it to reflect that she was the director of record for the facility. On July 30, 2026, at 3:45 p.m., president (P)-B stated they had been in contact with BELTSS and have submitted all documents for ALD/CNS-A to become licensed as the facility's LALD. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
01700 SS=D	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	01700		

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01700	Continued From page 3 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) assessed one of two resident's (R1) ability to self-administer medications. 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: R1 was admitted on October 22, 2025, with	01700		

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01700	Continued From page 4 diagnoses that included Parkinsonism (brain condition that causes movement problems, rigidity, and tremors). R1's service plan dated January 16, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, toileting, transfer assistance, escort/mobility assistance, behavior management, daily blood pressure checks, and medication administration. R1's Individualized Medication Management Plan dated July 24, 2026, indicated the following: -Self-Administration of Medication(s): "Med Self-Admin is not applicable" -Medication Management: medication management provided by [facility name] nursing, and medication administration provided by ULP (unlicensed personnel) On July 27, 2026, at 2:13 p.m., the surveyor observed ULP-F put a bowl with chocolate ice cream on the seat of R1's walker. At 2:16 p.m., the surveyor observed ULP-F take a spoon full of the ice cream and mix it in with a small amount of white powder, put the spoon with the powder back into the bowl of ice cream on R1's walker and tell R1 he should eat his ice cream. R1 left the ice cream on the seat of his walker while he walked the hallways unattended. Other residents were also in the hallways and common areas where R1 was walking. ULP-F walked away from R1 and returned to the medication cart. The surveyor inquired what the powder was that she mixed in with R1's ice cream. ULP-F stated she had crushed R1's 2:00 p.m. medications and mixed it into the ice cream because R1 had refused to take them whole. ULP-F stated sometimes the staff had to crush R1's medication and mix them in with ice cream or put them in	01700		

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01700	Continued From page 5 cookies without R1 knowing so he took the medication. ULP-F stated she would check on R1 later to see if he ate all the ice cream with his medications in it. ULP-F then went into the medication cart and prepared to administer medications for another resident. On July 27, 2026, at 2:23 p.m., the surveyor heard a loud noise and heard ULP-F state "oh no, you dropped your ice cream" to R1 as he walked past ULP-F. ULP-F left the area to administer medication to another resident and told assisted living director/clinical nurse supervisor (ALD/CNS)-A that R1 had dropped his ice cream. The surveyor observed the bowl of ice cream on the floor broken. The spoon with ice cream and medication was on the floor with the broken bowl. On July 28, 2026, at 9:05 a.m., ALD/CNS-A stated R1 could not self-administer any medications after setup due to his cognition and history of refusing medications. ALD/CNS-A stated the ULP would attempt to administer R1's medications to him in whole form; however if he refused, the ULP would crush the medications and mix it in with food and re-attempt to administer the medication. ALD/CNS-A stated the ULP could set the food with the medication down in front of R1 and walk away so that R1 didn't get paranoid about what was in the food; however, she expected the staff to continuously monitor R1 from a distance until R1 consumed all of the food with the medication in it. ALD/CNS-A stated the ULP would not be able to verify if R1 consumed some or all the medication if they did not continuously observe R1. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a	01700		

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01700	Continued From page 6 current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions The medication management record will be current and updated when there are any changes. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01730	Continued From page 7	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	01730		

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01730	Continued From page 8 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1 and 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: During the entrance conference on July 27, 2026, at approximately 9:30 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A stated the licensee provided medication management services to their residents at the facility. ALD/CNS-A stated medications were stored in a medication cart and medications that required refrigeration were stored in a locked refrigerator in the medication room. R1 R1 was admitted on October 22, 2025, with	01730		

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01730	Continued From page 9 diagnoses that included Parkinsonism (brain condition that causes movement problems, rigidity, and tremors). On July 27, 2026, at 2:13 p.m., the surveyor observed unlicensed personnel (ULP)-F put a bowl with chocolate ice cream on the seat of R1's walker. At 2:16 p.m., the surveyor observed ULP-F take a spoon full of the ice cream and mix in a small amount of white powder, put the spoon with the powder back into the bowl of ice cream on R1's walker and tell R1 he should eat his ice cream. R1 left the ice cream on the seat of his walker while he walked the hallways unattended. Other residents were also in the hallways and common areas where R1 was walking. ULP-F walked away from R1 and returned to the medication cart. The surveyor inquired what the powder was that she mixed in with R1's ice cream. ULP-F stated she had crushed R1's 2:00 p.m. medications and mixed it into the ice cream because R1 had refused to take them whole. ULP-F stated sometimes the staff had to crush R1's medication and mix them in with ice cream or put them in cookies without R1 knowing so he took the medication. ULP-F stated she would check on R1 later to see if he ate all the ice cream with his medications in it. ULP-F then went into the medication cart and prepared to administer medications for another resident. R1's service plan dated January 16, 2026, indicated R1 received services to include medication administration. R1's Individualized Medication Management Plan dated July 24, 2026, indicated the following: -Self-Administration of Medication(s): "Med Self-Admin is not applicable" -Medication Management: medication	01730		

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01730	Continued From page 10 management provided by [facility name] nursing, and medication administration provided by ULP R1's medication management plan lacked the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with medication management services -did not include self-administration of medications after setup R2 R2 was admitted on December 31, 2025, with diagnoses that included dementia. On July 2, 2026, at 11:17 a.m., the surveyor observed ULP-C check R2's blood sugar via Dexcom (device that continuously monitors blood sugar levels). ULP-C stated if R2's blood sugar results were greater than 151, the ULP would administer sliding scale insulin to R2. R2's service plan dated June 16, 2026, indicated R2 received services to include medication administration, blood sugar checks and Dexcom management. R2's medication administration record (MAR) dated July 2026, included the following insulin orders: -Insulin Aspart Flexpen; inject 0-14 units subcutaneously three times per day per sliding scale as directed: -Blood Sugar (BS) 0-150 = 0 units -BS 151-200 = 3 units -BS 201-250 = 6 units	01730		

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01730	Continued From page 11 -BS 251-300 = 8 units -BS 301350 = 10 units -BS 351-400 = 12 units -BS 401-500 = 14 units -Lantus Solostar 100 units/milliliter (ml); inject 12 units subcutaneously every morning and 8 units every evening R2's Individualized Medication Management Plan dated June 26, 2026, indicated the following: -secure storage of controlled medications, specify: secured and stored on medication cart under secondary lock box -secure storage of all other medications, specify: secured in locked medication cart R2's medication management plan did not include refrigeration storage for insulin. On July 28, 2026, at 9:03 a.m., ALD/CNS-A reviewed R1 and R2's medication management plans. ALD/CNS-A stated R1's medication management plan did not include identification of persons responsible for monitoring medication supplies and medication refill and did not include procedures for staff to notify the RN when a problem arises with medication management services. ALD/CNS-A stated R1 could not self-administer medications after set up. ALD/CNS-A stated insulin is stored in the secured refrigerator until opened for use. ALD/CNS-A stated R2's medication management plan did not include refrigeration storage for insulin. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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	34667	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOME OF NORTHFIELD	2501 JEFFERSON ROAD NORTHFIELD, MN 55057

(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
01730	Continued From page 12 a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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:	01880		

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01880	Continued From page 13 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. This had the potential to affect all 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 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 the entrance conference on July 27, 2026, at approximately 9:30 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A stated the licensee provided medication management services to their residents at the facility. ALD/CNS-A stated medications were stored in medication cart and medications that required refrigeration were stored in a locked refrigerator in the medication room. On July 27, 2026, at approximately 9:55 a.m. during the facility tour with ALD/CNS-A, the surveyor observed the medication room which was secured with a keypad entry. One medication cart and one medication refrigerator were observed inside the medication room. On July 28, 2026, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-D enter the medication room by pushing the door open. The door was not shut completely, so ULP-D did not have to enter the code on the keypad prior to	01880		

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01880	Continued From page 14 entering. ULP-D exited the medication room a couple of minutes later with medications to administer to another resident. When ULP-D left the medication room, the door did not shut all of the way. The surveyor observed an unlocked and unattended medication cart within the medication room. Other residents were sitting or walking by the area just outside the medication room. At 7:51 a.m., ULP-D returned to the unlocked medication room, enter the room by pushing the door open, documented medication administration on the computer and left the medication room. The medication cart was left unlocked, and the door was not closed all the way. At 7:57 a.m., ULP-D returned to the unlocked medication room, pushed the door open, prepared medications for a resident and left the medication room. The door was not closed all the way, and the surveyor observed the unlocked medication cart. On July 28, 2026, at 9:16 a.m., ALD/CNS-A stated if the medication cart was outside of the locked medication room she expected the ULP to lock the medication cart when unattended. ALD/CNS-A said if the medication cart was inside of the locked medication room, then the ULP wouldn't necessarily have to keep the cart locked since the door to the medication room required a code that only the nursing staff had. ALD/CNS-A stated if the ULP left the medication cart unlocked within the medication room, then the ULP should have made sure the door to the medication room was shut and secured prior to leaving to ensure no unauthorized person had access to the medication cart. The licensee's Medication Storage policy dated August 1, 2021, indicated that when medications are managed and stored by the licensee	01880		

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01880	Continued From page 15 medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as	01910		

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01910	Continued From page 16 required 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: R3 was admitted to the licensee on January 17, 2023, and discharged on June 11, 2026. R3's Medication Disposition Form dated June 11, 2026, indicated six medications were disposed of. Two of the medications listed (bisacodyl and Haloperidol) did not include the prescription number. On July 28, 2026, at 9:08 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A reviewed R3's medication disposition form and stated two of the medications did not include the prescription number. 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	01940		

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01940	Continued From page 17 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 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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (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	01940		

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01940	Continued From page 18 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 on December 31, 2025, with diagnoses that included dementia. On July 27, 2026, at 11:17 a.m., the surveyor observed unlicensed personnel (ULP)-C check R2's blood sugar via Dexcom (device that continuously monitors blood sugar levels). R2's service plan dated June 16, 2026, indicated R2 received services to include blood sugar checks and Dexcom management. R2's signed prescriber orders dated May 28, 2026, included the following: -Blood Sugar Check: Use Dexcom to check blood sugars nine times a day. May take blood sugars manually with finger poke. -Dexcom Sensor: Change every 10 days R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 19 services; and - 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. On July 28, 2026, at 9:12 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A reviewed R2's record and stated blood sugar checks and Dexcom management was listed on R2's service plan; however, R2's record did not include an individualized treatment management plan for R2's treatments as noted above. The licensee's Treatment and Therapy Management Plan dated August 1, 2021, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions	01940		

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01940	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of two residents (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).	01960		

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01960	Continued From page 21 The findings include: R2 was admitted on December 31, 2025, with diagnoses that included dementia. R2's service plan dated June 16, 2026, indicated R2 received services to include dressing, bathing, toileting, transfer assistance, escort/mobility assistance, behavior management, meal assistance, medication administration, blood sugar checks and Dexcom (device that continuously monitors blood sugar levels) management. R2's service plan did not include compression stockings. R2's signed prescriber orders dated March 12, 2026, included the following: -Apply compression stockings in a.m. (morning) and remove at p.m., (evening), edema of left lower extremity. R2's medication administration record (MAR) dated July 2026, did not include compression stockings. R2's service recap summary dated July 2026, did not include compression stockings. On July 27, 2026, at 1:11 p.m., unlicensed personnel (ULP)-C stated R2 did not wear compression stockings. R2's record lacked documentation of compression stocking services or documentation of the reason compression stockings were not administered as ordered. On July 28, 2026, at 9:09 a.m., assisted living director/clinical nurse supervisor (ALD/CNS)-A reviewed R2's prescriber order for compression	01960		

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01960	Continued From page 22 stockings and stated R2's family was supposed to obtain the compression stockings; however, they brought in a new type of regular socks instead. ALD/CNS-A stated she would update R2's primary care provider on R2 not wearing the compression stockings and obtain an order to discontinue the compression stockings. The licensee's Medication and Treatment Orders policy dated August 1, 2021, a current, written prescriber's order must be obtained for any treatment or mediation administration provided to a resident. The registered nurse is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders d. changes in orders are addressed in the resident's service plan and are communicated to the other staff No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ELYSIAN SENIOR HOMES OF NORTHF
2501 Jefferson Road
Northfield, MN 55057
Rice County
Parcel:

Phone:

License Info

License: HFID 34667

Risk:
License:
Expires on:
CFPM: Jessica Lee
CFPM #: 65614; Exp: 11/16/2029

Inspection Info

Report Number: F7990261017
Inspection Type: Full - Single
Date: 7/29/2026 Time: 10:04:06 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, COOLING, HANDWASHING, BAREHAND CONTACT AND NOROVIRUS PREVENTION. AN EMPLOYEE ILLNESS LOG WAS ONSITE.

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 Mankato District Office inspection report number F7990261017 from 7/29/2026

Benjamin D. Ische

Jessica Lee

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

ELYSIAN SENIOR HOMES OF NORTHF
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261017
Inspection Type: Full
Date: 7/29/2026
Time: 10:04:06 PM

Equipment Temperature: Product/Item/Unit: Arctic Air Reach in Milk**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

ELYSIAN SENIOR HOMES OF NORTHF
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261017
Inspection Type: Full
Date: 7/29/2026
Time: 10:04:06 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No