



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 17, 2026

Licensee
Villages Of Lonsdale LLC
1000 Birch Street Northeast
Lonsdale, MN 55046

RE: Project Number(s) SL26754017

Dear Licensee:

On September 8, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 17, 2026. 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,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 16, 2026

Licensee
Villages of Lonsdale LLC
1000 Birch Street Northeast
Lonsdale, MN 55046

RE: Project Number(s) SL26754017

ATTN: This letter has been amended from the letter dated July 15, 2026, to include an informal conference. No other changes have been made.

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 17, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

Villages of Lonsdale LLC

July 16, 2026

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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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Villages of Lonsdale. Please contact Jodi Johnson at 507-344-2730 on or before July 21, 2026, to schedule the conference call.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26754	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER VILLAGES OF LONSDALE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BIRCH STREET NORTHEAST LONSDALE, MN 55046		
(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: SL26754017-0 On June 15, 2026, through June 17, 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 49 residents; 38 receiving services under the Assisted Living with Dementia Care Facility license. 1290: An immediate order was issued on June 17, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 1750: An immediate correction order was issued on June 16, 2026, at a level 2/Widespread (F). The licensee took immediate action; however, the scope and level remain at F.	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 100 SS=F	1950: An immediate correction order was issued on June 16, 2026, at a level 2/Widespread (F). The licensee took immediate action; however, the scope and level remain at F. 144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to obtain accurate licensure when they applied for licensure for an assisted living facility, despite sharing one roof with an adjoining public library in the same building, without having an approved two-hour fire wall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 The findings include: The licensee's health facility identification (HFID) 26754 was located at 1000 Birch Street Northeast, Lonsdale, Minnesota (MN) 55046, and was attached to 1006 Birch Street Northeast, Lonsdale, MN 55046. On June 17, 2026, from 10:30 a.m. through 2:30 p.m., the Minnesota Department of Health (MDH) environmental engineer (EE) survey staff toured the facility with environmental services director (ESD)-I. During the tour, EE survey staff observed a three-story facility with a licensed capacity of 50 residents. The licensed area consisted of assisted living, and independent living apartments on all three floors, along with a memory care area on the first floor. The facility licensed area ends where the public library starts on the ground level. The assisted living area shares two interior walls and had two single personal doors, one on each wall. The assisted living area also had units on top of the library. Both personal doors only had a fire rating of 20 minutes, no documentation was available on site or provided to show that a 2-hour fire barrier was built between the areas. ESD-I stated the library does their own maintenance, but the facilities shared sprinkler systems and fire alarms systems. On June 17, 2026, at 2:00 p.m., EE survey staff advised the onsite nurse evaluator that the required two-hour fire barrier for approved separation between licensed areas could not be verified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 100			

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0 100	Continued From page 4 (21) days	0 100			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated June 17, 2026, for the specific	0 480			

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0 480	Continued From page 6 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during treatment and medication administration by two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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	0 510			

Minnesota Department of Health

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0 510	Continued From page 7 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: On June 15, 2026, at 11:38 a.m., the surveyor observed ULP-C remove R1's diabetic box from the medication cart which contained R1's diabetic supplies and insulin pens. ULP-C put gloves on, logged into the I-pad to verify R1's insulin orders. ULP-C then removed the insulin pen, swabbed port of the insulin pen with an alcohol prep pad, primed and wasted two units of insulin and then dialed the prescribed dose of 20 units. ULP-C removed her gloves, did not perform hand hygiene, and put a new pair of gloves on. ULP-C brought R1's insulin pen to R1's room and had R1 check her blood sugar via sensor. ULP-C then swabbed R1's abdomen with a alcohol prep pad and administered R1's insulin. ULP-C returned to the medication cart, removed gloves, and documented R1's blood sugar result and administration of insulin. ULP-C did not perform hand hygiene after she removed her gloves. On June 16, 2026, at 8:37 a.m., the surveyor observed ULP-D log into the I-pad to verify R1's insulin orders. ULP-D then unlocked the medication cart, removed R1's diabetic box that included diabetic supplies and insulin. ULP-D brought the diabetic box and insulin to R1 who was sitting at the dining room table. ULP-D had R1 check her blood sugar via sensor. ULP-D removed R1's insulin pen from the box, swabbed the port with an alcohol prep pad, prime and wasted two units of insulin and dialed the prescribed dose of 9 units. ULP-D asked R1 if	0 510			

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0 510	Continued From page 8 she wanted to return to her room or stay in the dining room when ULP-D administered the insulin. R1 stated she wanted to stay in the dining room. ULP-D administered R1's insulin in her abdomen. ULP-D gathered the diabetic box and returned it to the medication cart and documented R1's blood sugar result and administration of insulin. ULP-D removed his gloves, did not perform hand hygiene, put on a new pair of gloves and prepared medications to be administrated to R2. On June 16, 2026, at 8:44 a.m., ULP-D put on a pair of gloves, removed R2's diabetic box that included R2's glucometer and insulin pens. ULP-D brought the diabetic box and insulin to R2's room. ULP-D wiped R2's fingertip with an alcohol prep pad, pricked R2's fingertip with a lancet, squeezed R2's finger and placed a drop of blood onto the test strip. ULP-D then prepared and administered R2's insulin in his abdomen. After administering R2's insulin ULP-D returned to the medication cart removed gloves, did not perform hand hygiene, documented R2's blood sugar result and administration of insulin. ULP-D then put on a new pair of gloves, removed the test strip from the glucometer and disposed of the test strip, removed gloves and did not perform hand hygiene. On June 17, 2026, at 12:28 p.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to perform hand hygiene prior to applying gloves and again after gloves were removed. CNS-B further stated the ULP should remove gloves and perform hand hygiene prior to leaving the resident's room. The licensee's Hand Hygiene policy dated March 10, 2026, indicated hands must be washed:	0 510			

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0 510	Continued From page 9 a. Before and after direct contact with a resident b. When moving from a contaminated site to a clean site during resident care c. Before and after contact with environmental surfaces or equipment in the resident's immediate vicinity d. When hands are visibly soiled or contaminated e. After removing gloves or gowns f. Before and after eating g. After using the restroom h. When caring for residents with diarrhea illness i. When a "build up" of emollients is felt after repeated use of alcohol-based hand sanitizer j. Before preparing or handling food No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 630			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER VILLAGES OF LONSDALE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BIRCH STREET NORTHEAST LONSDALE, MN 55046		
(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
0 630	Continued From page 10 review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2 and 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: R2 R2 was admitted on April 9, 2025, with diagnoses that included diabetes. On June 16, 2026, at 8:44 a.m., the surveyor observed unlicensed personnel (ULP)-D administer insulin to R2. R2's service plan dated March 5, 2026, indicated R2 received services to include grooming, bathing, dressing, toileting, transfer assistance, mobility/ambulation assistance, diabetic management and medication administration. R2's IAPP Form dated May 28, 2026, indicated R2 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults.	0 630			

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0 630	Continued From page 11 R3 R3 was admitted on June 18, 2025, with diagnoses that included diabetes. On June 15, 2026, at 12:05 p.m., the surveyor observed ULP-C administer medications to R3. R3's service plan dated May 6, 2026, indicated R3 received services to include grooming, bathing, dressing, toileting, mobility/ambulation, bed mobility, transferring, Tubi-grips, oxygen assistance, medication administration, twice daily blood sugar checks and insulin administration three times a day. R3's IAPP Form dated May 19, 2026, indicated R3 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R3 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. On June 17, 2026, at 12:30 p.m., quality director (QD)-E stated all residents residing in memory care were considered vulnerable adults and susceptible to abuse, and their IAPP should have indicated they were at risk to be abused. QD-E and clinical nurse supervisor (CNS)-B reviewed R2 and R3's IAPP and stated it did not indicate that they were at risk to be abused and R2 and R3 both resided in memory care. The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated all residents are considered vulnerable adults and the staff would assess each resident for vulnerability, create and implement and individualized abuse prevent plan to prevent harm.	0 630			

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0 630	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test and failed to include documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-C).	0 660			

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0 660	Continued From page 13 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-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. ULP-C's record included the following: -Baseline TB Screening Tool dated October 9, 2025, which was completed at a sister facility -a negative quantiferon test dated November 5, 2025; however, the blood test was not completed within 90 days of hire. On June 17, 2026, at 1:16 p.m., quality director (QD)-E stated ULP-C's baseline TB Screening Tool and blood test were from a sister facility and were not completed within 90 days of hire at the licensee. The licensee's Tuberculosis Prevention and Control policy dated August 10, 2022, indicated TB screening and testing of all volunteers and employees would be completed upon hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 730	Continued From page 14	0 730			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

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0 730	Continued From page 15 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one discharged resident's record (R4) included a discharge summary with the required content. 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 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: R4 was admitted to the licensee on October 28, 2025, and discharged on March 31, 2026. R4's discharge summary dated March 31, 2026, failed to include: - a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that	0 730			

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0 730	Continued From page 16 includes the resident status, including baseline and current mental, behavioral, and functional status; - postdischarge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The postdischarge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medication and nonmedical services the resident will need. On June 17, 2026, at 12:47 p.m., quality director (QD)-E stated the licensee had updated their discharge summary and thought it included all the required content. Clinical nurse supervisor (CNS)-B stated R4's discharge summary did not include the content as listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	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.	0 775			

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0 775	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026, for specific violations related to the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810			

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0 810	Continued From page 18 (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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810			

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0 810	Continued From page 19 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026, for specific violations related to the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	0 900			

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0 900	Continued From page 20 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for the two of three residents (R1 and 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: R1 was admitted on June 5, 2025, with diagnoses that included diabetes and dementia. R1's medication administration record (MAR) dated June 2025, indicated R1 received medication administration services starting on June 5, 2025. R1's Assisted Living Contract was signed by R1's representative on June 25, 2026, 20 days after R1 was admitted and started receiving services. R3 R3 was admitted on June 18, 2025, with diagnoses that included diabetes. R3's MAR dated June 2025, indicated R3	0 900			

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0 900	Continued From page 21 received medication administration services starting on June 18, 2025. R3's Assisted Living Contract was signed by R3's representative on June 20, 2026, two days after R3 was admitted and started receiving services. On June 17, 2026, at 12:17 p.m., licensed assisted living director (LALD)-A stated R1 and R3's contracts were not signed prior to providing services to R1 and R3. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 22 Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three unlicensed personnel (ULP-H). This had the potential to affect all residents residing in the facility. This resulted in an immediate order on June 17, 2026. In addition, the licensee failed to ensure background studies were affiliated with the correct health identification (HFID) for three of three employees (ULP-C, ULP-K and cook (C)-J). This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-H was hired on July 15, 2025, to provide direct care and services to the facility's residents. ULP-H's employee record contained a Notice of Background Study Disqualification dated December 21, 2023, which was affiliated with a sister facility HFID 30490. In addition, ULP-H's record included a letter dated February 7, 2024, which indicated the following: -"As a result of our review, the Department has set aside the disqualification. The individual continues to have a disqualification, but you may allow him/her to provide services at the above-name program (HFID 30490). The individual has been informed of this decision".	01290			

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01290	Continued From page 23 ULP-H's employee record lacked evidence of a background study clearance letter for this licensee (HFID 26754). On June 17, 2026, at 10:26 a.m., licensed assisted living director (LALD)-A stated ULP-H was originally hired at a sister facility and transferred to this licensee. ULP-H was an on-call employee. LALD-A stated ULP-H last worked independently on June 14, 2026, providing direct care services to residents. ULP-C ULP-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record contained Background Study Clearance letter dated October 1, 2025, from a sister facility. However, the document was not affiliated with the facility's license. ULP-K ULP-K was hired on April 17, 2025, to provide direct care and services to the facility's residents. ULP-K's employee record contained Background Study Clearance dated April 18, 2025, from a sister facility. However, the document was not affiliated with the facility's license. C-J was hired on May 11, 2023, to provide services to the facility's residents. C-J's employee record contained Background Study Clearance dated May 5, 2023, from a sister facility. However, the document was not affiliated with the facility's license. On June 17, 2026, at 10:50 a.m., QD-E stated	01290			

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01290	Continued From page 24 ULP-C, ULP-K and C-J's stated background studies were affiliated with sister facilities and not affiliated with the licensee's HFID. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated a background study on an individual after a conditional off of engagement has been made and before an individual provides direct contact services to individuals receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on June 17, 2026, to mitigate immediate risk to residents; however, the scope and level remains at I.	01290			
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	01440			

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01440	Continued From page 25 calendar days after the date on which the individual begins working for the facility and first 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 staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-C). 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-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. On June 15, 2026, at 12:05 p.m., the surveyor observed ULP-C administer medications to R3. ULP-C's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee.	01440			

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01440	Continued From page 26 On June 17, 2026, at 1:18 p.m., clinical nurse supervisor (CNS)-B stated ULP-C's employee record lacked evidence of a 30-day supervision of a delegated task by the RN. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform al the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

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01470	Continued From page 27 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) completed an orientation to assisted living facility licensing requirements and regulations before providing services to 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, 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-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Assisted Living Bill of Rights; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license.	01470			

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01470	Continued From page 29 On June 17, 2026, at 1:09 p.m., clinical nurse supervisor (CNS)-B stated ULP-C had not been assigned or completed all the required orientation courses because she had transferred from a sister facility and thought all that training was transferable. The licensee's Orientation and Annual Training policy dated August 1, 2021, indicated at minimum, orientation must include the following topics: a. The facilities organization chart and roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure or services (UDALSA); b. An overview of Minnesota's assisted living license; c. An introduction and review of all of our facility's policies and procedures related to the provision of assisted living services; d. Handling emergencies and use of emergency services; e. Reporting the maltreatment of vulnerable minors or adults f. The assisted living Bill of Rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; h. Our programs' system for receiving and responding to complaints; where to report complaints and information on the Office of Health Facility Complaints and the MAARC and how residents, staff and others may contact these agencies with complaints; i. The consumer advocacy services of the Ombudsman of Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470			

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01470	Continued From page 30 Services, county managed care advocates, or other relevant advocacy services: j. A review of the types of assisted living services the employee will be providing and the scope of facility's license; k. An explanation of age-related hearing loss; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620			

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01620	Continued From page 31 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 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) conducted ongoing nursing assessments not to exceed 90 days for one of three 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) 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	01620			

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01620	Continued From page 32 only occasionally). The findings include: R2 was admitted on April 9, 2025, with diagnoses that included diabetes. R2's service plan dated March 5, 2026, indicated R2 received services to include grooming, bathing, dressing, toileting, transfer assistance, mobility/ambulation assistance, diabetic management and medication administration. R2's ongoing nursing assessments dated December 31, 2025, February 17, 2026, and May 19, 2026, were reviewed. The May 19, 2026, assessment was completed 91 days after the date of the previous assessment, thus exceeding 90 calendar days. On June 17, 2026, at 12:50 p.m., quality director (QD)-E reviewed R2's record and stated the May 19, 2026, assessment was completed late. The licensee's Nursing Assessment policy dated April 18, 2022, indicated the RN will reassess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 33 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for three of three residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01640			

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01640	Continued From page 34 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on June 5, 2025, with diagnoses that included diabetes and dementia. R1's service plan dated June 5, 2025, indicated R1 received services to include twice daily blood sugar checks. R1's signed prescriber orders dated June 2, 2026, included the following: -Blood sugar monitoring four times a day; 9:30 a.m., 12:30 p.m., 5:30 p.m., and 9:30 p.m. R1's medication administration record (MAR) dated June 2026, indicated R1's blood sugar check was checked four times a day. R1's service plan did not include four times a day blood sugar checks. R2 R2 was admitted on April 9, 2025, with diagnoses that included diabetes. On June 16, 2026, at 8:44 a.m., the surveyor observed ULP-D administer insulin to R2. R2's service plan dated March 5, 2026, indicated R2 received services to include twice daily medication administration and twice daily blood sugar checks. R2's signed prescriber orders dated June 2, 2026, included the following: -Blood sugar check: one time per day	01640			

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01640	Continued From page 35 R2's MAR dated June 2026, indicated the staff administered medications four times a day (8:00 a.m., 12:00 p.m., 2:00 p.m., and 8:00 p.m.) and once a day blood sugar check at 8:30 a.m. R2's service plan did not include four times a day medication administration and once a day blood sugar check. R3 R3 was admitted on June 18, 2025, with diagnoses that included diabetes. R3's service plan dated May 6, 2026, indicated R3 received services to include grooming, bathing, dressing, toileting, mobility/ambulation, bed mobility, transferring, Tubi-grips, oxygen assistance, medication administration, twice daily blood sugar checks and insulin administration three times a day. R3's MAR dated June 2026, included the following: -Blood Sugar Checks one time per day -Bandage Treatment two times a day: 1) cleanse area with wound cleaner. 2) Pat dry with gauze. 3) Cover wound with non-adherent pad and wrap with Keri. 4) Staff to report signs or symptoms of infection and notify nurse with any changes or concerns. -Blood Pressure (BP) and Pulse (P) checks: One time a day, every week on Tuesday and Friday -Oxygen Saturation Level: Two times per day -Weight order: one time per day, every week on Tuesday and Saturday The MAR did not include insulin administration, as indicated on the service plan. R3's service plan did not include once daily blood	01640			

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01640	Continued From page 36 sugar checks, bandage treatment, twice weekly BP and P checks, twice daily oxygen saturation checks and twice weekly weights. On June 17, 2026, at 12:54 p.m., quality director (QD)-E and clinical nurse supervisor (CNS)-B reviewed R1, R2 and R3's service plans. CNS-B stated R1's service plan should have indicated R1 received four times a day blood sugar checks, not once a day blood sugar checks. CNS-B stated R2's service plan should have indicated R2 received medication administration four times a day and once a day blood sugar check. CNS-B stated R3's service plan should have included once a day blood sugar checks, twice daily bandage treatment, twice a week BP and P checks, twice daily oxygen saturation checks and twice weekly weights. CNS-B further stated R3 did not receive insulin administration. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse and as requested and/or agreed upon by the resident or the resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730			

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01730	Continued From page 37 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 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	01730			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 38 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 three of three residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 15, 2026, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents at the facility. CNS-B stated medications were stored in medication carts and overflow medications were stored in the medication room in memory care. R1 R1 was admitted on June 5, 2025, with diagnoses that included diabetes and dementia. On June 15, 2026, at 11:38 a.m., the surveyor observed unlicensed personnel (ULP)-C administer insulin to R1.	01730			

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01730	Continued From page 39 R1's service plan dated June 5, 2025, indicated R1 received services to include medication administration. R1's individualized medication management plan (found within the service plan) dated June 5, 2025, indicated the following: -Medication Storage- insulin in refrigerator. Unopened insulin is stored in medication fridge and temperature is monitored. R1's medication plan did not include storage in the medication cart or central storage in the medication room. R2 R2 was admitted on April 9, 2025, with diagnoses that included diabetes. On June 16, 2026, at 8:44 a.m., the surveyor observed ULP-D administer insulin to R2. R2's service plan dated March 5, 2026, indicated R2 received services to include medication administration. R2's individualized medication management plan (found within the service plan) dated March 5, 2026, indicated the following: -Medication Storage: Assistance needed for medication storage. Medications will be kept in a locked medication cart in the memory care unit. R2's medication plan did not include storage refrigeration storage for insulin or central storage in the medication room. R3 R3 was admitted on June 18, 2025, with	01730			

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01730	Continued From page 40 diagnoses that included diabetes. On June 15, 2026, at 12:05 p.m., the surveyor observed ULP-C prepare medications for administration for R3. ULP-C could not locate one medication and went to the medication room to check R3's overflow bin. ULP-C stated the medication was not in the overflow bin and would call the pharmacy to ensure the medication was refilled. R3's service plan dated May 6, 2026, indicated R3 received services to include medication administration. R3's individualized medication management plan (found within the service plan) dated May 6, 2026, indicated the following: -Medication Storage: Assistance needed. Medications will be kept in a locked medication cart in the memory care unit. R3's medication plan did not include central storage in the medication room. On June 17, 2026, at 12:59 p.m., quality director (QD)-E reviewed R1, R2, and R3's medication management plans and stated R1, R2, and R3's medication plans did not include the medication storage as noted above. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a 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, treatment and therapy management services that	01730			

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01730	Continued From page 41 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, treatment and therapy services; d. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; e. Identification of medication, treatment and therapy 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, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services 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			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750			

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01750	Continued From page 42 proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) had been trained and competency tested by a licensed registered nurse (RN) prior to administering medications. This resulted in an immediate correction order identified on June 16, 2026. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2026, at approximately 9:45 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated orientation for new ULP included online training, and shadow shifts where the ULP observed current staff perform delegated tasks including medication and treatment administration. Then the RN completed competency testing with the new ULP. Once the competency testing was completed, the ULP	01750			

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01750	Continued From page 43 could perform hands-on tasks such as medication and treatment administration. ULP-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. On June 15, 2026, at 12:05 p.m., the surveyor observed ULP-C administer oral medications to R3. ULP-C's employee file included medication administration training and competencies dated December 2, 2025; however, these were from a sister facility where ULP-C previously worked. ULP-C's employee file lacked evidence training and competencies for medication administration had been completed by a RN. On June 16, 2026, at 9:44 a.m., CNS-B stated ULP-C had not been trained or competency tested on medication or treatment administration. CNS-B stated she thought the training ULP-C received at a sister facility met the training and competency requirements. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the RN may delegate to ULP the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the ULP have satisfied the training requirements. a. The RN has communicated information about the medication, treatment, or therapy to the resident and provided education if needed b. Before performing the procedures, the RN has instructed the ULP in the proper methods to	01750			

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01750	Continued From page 44 administer the medications, treatment and therapy and the ULP have demonstrated the ability to competently follow the procedures c. The RN has developed written, specific instructions for each resident d. The RN has communicated with the ULP about the individual needs of the resident; and e. The RN has documented that the ULP have been trained and have demonstrated competency to follow procedures Documentation of each ULP's training and competency to assist or administer medications, treatment ant therapy will be retained in the personnel record of each staff person who has satisfied the above training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on June 16, 2026, to mitigate immediate risk to residents; however, the scope and level remains at F.	01750			
01790 SS=D	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	01790			

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01790	Continued From page 45 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; (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	01790			

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01790	Continued From page 46 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 the registered nurse (RN) trained and competency tested two of two unlicensed personnel (ULP-C and ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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-C ULP-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-D	01790			

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01790	Continued From page 47 ULP-D was hired on May 18, 2026, to provide direct care and services to the facility's residents. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On June 17, 2026, at 1:18 p.m., quality director (QD)-E stated training and competency testing on unplanned time away is part of the ULP orientation. However, after reviewing ULP-C and ULP-D's training documents, neither ULP-C nor ULP-D had documentation of training or competency testing for unplanned time away in their record. The licensee's Medications to be Given When Away From Home policy dated August 1, 2021, indicated for situations when there will be a short-term absence (not to exceed seven calendar days) that is not known in advance and a licensed nurse is not available to put the medications into a container for the resident or the resident's responsible person to take out of the building, the RN will train unlicensed staff to follow the policy when giving medications to the resident or resident's responsible person to take out of the building. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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	01880			

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01880	Continued From page 48 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. 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: On June 16, 2026, at 6:56 a.m., the surveyor observed an unattended and unlocked medication cart in memory care for approximately five minutes. Other residents were in the common area near the unlocked medication cart. On June 16, 2026, at 1:00 p.m., the surveyor observed an unattended and unlocked medication cart in memory care for approximately 15 minutes. Other residents and visitors were in the common area near the unlocked medication cart. On June 17, 2026, at 1:17 p.m., clinical nurse supervisor (CNS)-B stated the medication cart should be locked when not in use and when staff are not present at the cart.	01880			

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01880	Continued From page 49 The licensee's Storage of Medication policy dated January 6, 2021, indicated medications will be handled and stored per acceptable standards. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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 time sensitive medications had an opened date 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:	01890			

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01890	Continued From page 50 R1 R1 was admitted on June 5, 2025, with diagnoses that included diabetes and dementia. R1's service plan dated June 5, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated June 2025, included: - Insulin Lispro pen 100 units/milliliter (ml): inject 20 units subcutaneously before meals. On June 15, 2026, at 11:38 a.m., the surveyor observed unlicensed personnel (ULP)-C remove a insulin Lispro pen from a small box in the medication cart with R1's name on it. ULP-C stated all residents with insulin had a separate box in the medication cart that stored their diabetic supplies and insulin. ULP-C prepared R1's insulin as prescribed. The insulin pen had a sticker on it for staff to document the open date; however, it was blank. R2 R2 was admitted on April 9, 2025, with diagnoses that included diabetes. R2's service plan dated March 5, 2026, indicated R2 received services to include medication administration. R2's MAR dated June 2026, included: -Basaglar Kwik Pen 100 units/ml; Inject 9 units subcutaneously one time per day On June 16, 2026, at 8:44 a.m., the surveyor observed ULP-D remove a basaglar insulin pen from a small box in the medication cart with R2's name on it. ULP-D prepared R2's insulin as	01890			

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01890	Continued From page 51 prescribed. The insulin pen had a sticker on it for staff to document the open date; however, it was blank. On June 17, 2026, at 1:04 p.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to document the open date for all insulin pens at the time a new one is first used. The Basaglar Kwikpen instructions for use dated August 26, 2022, indicated to throw away an opened insulin pen after using it for 28 days, even if there is still insulin left in it. The Insulin Lispro Kwikpen instructions for use dated July 2023, indicated throw away the insulin lispro pen you are using after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940			

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01940	Continued From page 52 (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 three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on June 18, 2025, with	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26754	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER VILLAGES OF LONSDALE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BIRCH STREET NORTHEAST LONSDALE, MN 55046		
(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
01940	Continued From page 53 diagnoses that included diabetes. On June 16, 2026, at 12:54 p.m., the surveyor observed unlicensed personnel (ULP)-D check R3's blood pressure and pulse. R3's service plan dated May 6, 2026, indicated R3 received services to include grooming, bathing, dressing, toileting, mobility/ambulation, bed mobility, transferring, Tubi-grips, oxygen assistance, medication administration, twice daily blood sugar checks and insulin administration three times a day. R3's service plan did not include once daily blood sugar checks, bandage treatment, twice weekly blood pressure (BP) and pulse (P) checks, twice daily oxygen saturation checks and twice weekly weights. R3's signed prescriber orders dated June 2, 2026, included the following: -Bandage Treatment two times a day: 1) cleanse area with wound cleaner. 2) Pat dry with gauze. 3) Cover wound with non-adherent pad and wrap with Kerlix. 4) Staff to report signs or symptoms of infection and notify nurse with any changes or concerns. -Bandage Treatment as needed (PRN): 1) cleanse area with wound cleaner. 2) Pat dry with gauze. 3) Cover wound with non-adherent pad and wrap with Kerlix. 4) Staff to report signs or symptoms of infection and notify nurse with any changes or concerns. -BP and P: check one time per day every week on Tuesdays and Fridays -Oxygen Saturation checks: two times per day every day. If oxygen saturations is less than 90% have client wiggle their fingers and recheck. If oxygen saturation is still less than 90% report to	01940			

Minnesota Department of Health

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01940	Continued From page 54 nurse -Oxygen: continuous supplemental oxygen at 2 liters per nasal cannula. Apply nasal cannula at nighttime and ensure it is set to two liters. -Oxygen PRN: apply oxygen via nasal cannula and set to two liters as needed for oxygen saturations below 88% or shortness of breath during the day. -Weight: check one time per week every Tuesday and Saturday before breakfast. R3's MAR dated June 2026, included the following: -Bandage Treatment two times a day: 1) cleanse area with wound cleaner. 2) Pat dry with gauze. 3) Cover wound with non-adherent pad and wrap with Kerlix. 4) Staff to report signs or symptoms of infection and notify nurse with any changes or concerns. -BP and P checks: One time a day, every week on Tuesday and Friday -Oxygen Saturation Level: Two times per day -Weight order: one time per day, every week on Tuesday and Saturday R3's Individualized Treatment/Therapy Management Plan (found within the service plan) dated May 6, 2026, failed to include the following; -statement of the type of services that will be provided (BP and P checks, oxygen saturation checks, bandage treatment) -documentation of specific resident instructions relating to the treatments or therapy administration (oxygen management) On June 17, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-B reviewed R3's treatment plan and stated it did not include the required content as noted above.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26754	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2026
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01940	Continued From page 55 The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: g. A statement describing the medication, treatment and therapy management services that will be provided; h. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; i. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; j. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; k. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel; l. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services 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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26754	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2026
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01950 SS=F	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 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 one of one unlicensed personnel (ULP-C) had been competency tested by a licensed registered nurse (RN) prior to administering treatments. This resulted in an immediate correction order identified on June 16, 2026. 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	01950			

Minnesota Department of Health

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01950	Continued From page 57 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2026, at approximately 9:45 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated orientation for new ULP included online training, shadow shifts where the ULP observed current staff perform delegated tasks, including medication and treatment administration. Then, the RN completed competency testing with the new ULP. Once the competency testing was completed, the ULP could perform hands-on tasks such as medication and treatment administration. ULP-C was hired on February 25, 2026, to provide direct care and services to the licensee's residents. On June 15, 2026, at 11:38 a.m., the surveyor observed ULP-C check R1's blood sugar via Dexcom sensor (device that continuously monitors blood sugar levels) and administer insulin. ULP-C stated recently R1 couldn't locate her sensor, so she had to manually check R1's blood sugar via a finger poke. R2's medication administration record (MAR) dated June 2026, indicated ULP-C checked R2's blood sugar via finger poke on June 1,2,7, and 15, 2026. ULP-C's employee file included treatment administration (including blood sugar checks) training and competencies dated December 2, 2025; however, these were from a sister facility ULP-C's employee file lacked evidence training	01950			

Minnesota Department of Health

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01950	Continued From page 58 and competencies for treatment administration had been completed by an RN at this facility. On June 16, 2026, at 9:44 a.m., CNS-B stated ULP-C had not been trained or competency tested on medication or treatment administration. CNS-B stated she thought the training ULP-C received at a sister facility met the training and competency requirements. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the RN may delegate to ULP the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the ULP have satisfied the training requirements. f. The RN has communicated information about the medication, treatment, or therapy to the resident and provided education if needed g. Before performing the procedures, the RN has instructed the ULP in the proper methods to administer the medications, treatment and therapy and the ULP have demonstrated the ability to competently follow the procedures h. The RN has developed written, specific instructions for each resident i. The RN has communicated with the ULP about the individual needs of the resident; and j. The RN has documented that the ULP have been trained and have demonstrated competency to follow procedures Documentation of each ULP's training and competency to assist or administer medications, treatment ant therapy will be retained in the personnel record of each staff person who has satisfied the above training and competency requirements.	01950			

Minnesota Department of Health

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01950	Continued From page 59 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on June 16, 2026, to mitigate immediate risk to residents; however, the scope and level remains at F.	01950			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, staff, and visitors of the facility. 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 June 16, 2026, at 12:54 p.m., the surveyor observed R3's room which had five unsecured	02310			

Minnesota Department of Health

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02310	Continued From page 60 oxygen cylinders on the floor near her bed. On June 17, 2026, at 1:09 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the unsecured oxygen cylinders in R3's room and would secure the cylinders and educate staff on oxygen storage. The licensee's Oxygen policy dated May 23, 2025, indicated oxygen tanks must be secured with chains, racks or in stands. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted	02410			

Minnesota Department of Health

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02410	Continued From page 61 in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for one of three residents (R1) during insulin 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 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: On June 16, 2026, at 8:37 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R1's insulin for administration. ULP-D brought the insulin pen to R1 who was sitting at the dining room table. ULP-D asked R1 if she wanted to return to her room or stay in the dining room when ULP-D administered the insulin. R1 stated she wanted to stay in the dining room. ULP-D then lifted up R1's dress and exposed R1's	02410			

Minnesota Department of Health

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02410	Continued From page 62 abdomen, incontinence pull up and bare legs and administered the insulin. During the insulin administration another resident who was sitting at a nearby table stated, "oh look, she must be diabetic, see, she is getting a shot", several residents at the table turned around and watched ULP-D administer R1's insulin. ULP-D failed to turn R1 away from others or shield R1's exposed abdomen and legs from other resident's while administering insulin. On June 17, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated it was preferred that insulin administration was completed in the resident's room to maintain privacy. However, if a resident didn't want to leave a common area for the insulin administration the staff would administer it per the resident's request. CNS-B stated even though R1 requested to remain in the dining room, ULP-D should have positioned R1 and himself so that others could not see R1's exposed abdomen, pull up and legs while administering insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Villages of Lonsdale
1000 BIRCH STREET NE
Lonsdale, MN 55046
Rice County
Parcel:

Phone:

License Info

License: HFID 26754

Risk:
License:
Expires on:
CFPM: Stephanie Moe
CFPM #: 107666; Exp: 8/10/2027

Inspection Info

Report Number: F7990261011
Inspection Type: Full - Single
Date: 6/17/2026 Time: 10:59 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A Priority Level: Priority 3 CFP#: 39

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

COMMENT: DISCONTINUE STORING FOOD ON THE FLOOR OF THE WALK IN FREEZER AND DRY STORAGE ROOM.

Comply By: 6/18/2026 Originally Issued On: 6/17/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-303.11B Priority Level: Priority 3 CFP#: 56

MN Rule 4626.1470B Provide at least 20 foot candles (215 LUX) of light intensity at a distance of 30 inches from the floor for areas where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged foods are sold or offered for consumption, inside equipment including reach-in and under counter refrigerators, in utensil storage areas, warewashing areas, and in toilet rooms.

COMMENT: REPLACE BURNT OUT LIGHT BULB IN CENTAUR REACH IN 2 DOOR COOLER.

Comply By: 6/24/2026 Originally Issued On: 6/17/2026

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, HANDWASHING, NOROVIRUS, AND BAREHAND CONTACT 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 F7990261011 from 6/17/2026

Stephanie Moe

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

Page: 1

Establishment Info

Villages of Lonsdale
Lonsdale
County/Group: Rice County

Inspection Info

Report Number: F7990261011
Inspection Type: Full
Date: 6/17/2026
Time: 10:59 AM

Food Temperature: **Product/Item/Unit:** CENTAUR REACH IN COOLER TOMATO; **Temperature Process:** Cold-Holding

Location: Reach-in Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** TRUE 1 DOOR REACH IN COOLER MILK; **Temperature Process:** Cold-Holding

Location: Reach-in Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** WALK IN COOLER CHEESE; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HOT HOLD MASH POTATOES; **Temperature Process:** Hot-Holding

Location: Steam Table at 145 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

Page: 1

Establishment Info

Villages of Lonsdale
Lonsdale
County/Group: Rice County

Inspection Info

Report Number: F7990261011
Inspection Type: Full
Date: 6/17/2026
Time: 10:59 AM

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

Location: Dishwashing Area **Equal To** 162 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

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL26754017-0	Date: June 17, 2026
Facility Name: VILLAGES OF LONSDALE	
Facility Address: 1000 BIRCH ST NE, LONSDALE, MN 55046	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: The hard-wired smoke alarms in multiple resident rooms were over 10 years past the manufacturer date. All smoke alarms shall be replaced with smoke alarms having the same type of power supply.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: On the exterior of garage 3/4 there was a yellow extension cord that had the plug removed and was wired into the exterior light of the garage with the cord running into the garage for power.

☒ TAG IDENTIFICATION: 0810

Project Number: SL26754017-0

Facility Name: VILLAGES OF LONSDALE

Date: June 17, 2026

Page | 1

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

Comments: : The Licensed assisted living director (LALD)-A provided staff training records from a web-based training site, the training documentation record lacked any training on the facility specific fire safety and evacuation plan.

3. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. LALD-A stated that the training was scheduled but was canceled 3 different times.