Electronically Delivered

May 27, 2026

Licensee
Arbor Terrace
700 Northwest 2nd Avenue
Rochester, MN 55901

RE: Project Number(s) SL20146016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 6, 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:

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 $1,000.00**. 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.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20146	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE	700 NW 2ND AVENUE ROCHESTER, MN 55901

(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: SL20146016-0 On May 4, 2026, through May 6, 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 78 residents; 47 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on May 5, 2026, at a level 3/Widespread (I). The licensee took action on May 5, 2026; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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	0 480		

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0 480	Continued From page 2 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 5, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=E	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, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		

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0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 780		

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0 780	Continued From page 5 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=E	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. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 6 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, record review, and interview, 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 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:	0 810		

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0 810	Continued From page 7 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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: Based on observation, interview, and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS) with the assisted living with dementia care license for two of 49 employees (student/interim housing	01290		

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01290	Continued From page 8 coordinator SIHC-A, and maintenance worker (MW)-G). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on May 5, 2026. This practice resulted in a level three violation (a violation that harmed a 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 potential to affect a large portion or all of the residents). The findings include: On May 4, 2026, at 2:45 p.m., the surveyor received the licensee's NETStudy 2.0 roster for health facility identification (HFID) 20146, as printed on May 4, 2026. On May 4, 2026, at 3:00 p.m., the surveyor requested further clarification of background studies for SIHC-A and MW-G as they were not found on the licensee's NETStudy 2.0 roster. BACKGROUND STUDY CLEARANCE SIHC-A SIHC-A started her role as a student/interim housing coordinator with the licensee on June 2, 2025. On May 4, 2026, at 11:45 a.m., the surveyor and SIHC-A completed a tour of the facility. SIHC-A conducted the tour independently and was not directly supervised by any of the licensee's staff. In addition, the surveyor observed several	01290		

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01290	Continued From page 9 residents walking through the hallways of the facility during that time. On May 5, 2026, at 10:30 a.m., SIHC-A and licensed assisted living director (LALD)-B stated SIHC-A was not employed by the licensee but was a student at a university in Wisconsin. The university had a contract with the skilled nursing facility (long term care facility located next door) associated with the facility, and was currently training at this licensed facility. SIHC-A stated she had completed a background study with the university. LALD-B stated it was understood that the background study completed by the university covered the background study requirement and further stated SIHC-A had started the background study clearance process through NETStudy 2.0 as the licensee was planning to hire her when she completed school this semester. On May 5, 2026, at 12:45 p.m., SIHC-A and LALD-B provided the surveyor with a background study clearance completed April 9, 2025; however, the background study clearance was not completed through NETStudy 2.0 as required. On May 5, 2026, at 1:00 p.m., LALD-B stated there was always someone with SIHC-A as she was still a student and learning, and it would be a rare occurrence for her to not have direct supervision by an employee with a clear background study. BACKGROUND STUDY AFFILIATION MW-G MW-G was hired on June 5, 2023, and worked for the maintenance department for both the skilled nursing facility and for the licensee. On May 5, 2026, at 10:30 a.m., LALD-B provided	01290		

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01290	Continued From page 10 the surveyor with documentation of MW-G's cleared background study dated May 19, 2023, and was affiliated with the skilled nursing facility (HFID-427) connected to the facility. On May 5, 2026, at 2:25 p.m., LALD-B stated MW-G would have not been under direct supervision while working in the licensee's facility. MW-G's background study lacked affiliation with the licensee's HFID number 20146. The licensee failed to affiliate MW-G's background study to their facility license before having direct contact with residents. The licensee's Pre-Employment Requirements policy dated January 5, 2026, indicated all prospective employees must undergo a criminal background check in compliance with Minnesota Statutes, Section 364.021, before a formal job offer is made. - the background check may include a review of criminal history, employment verification, education verification, and professional licenses or certifications. - candidates applying for positions involving direct contact with vulnerable populations (e.g., healthcare, education) must undergo a more extensive background check as mandated by Minnesota law. - for any contractors, students, interns, their agency is responsible for completing the background studies. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on May 5, 2026;	01290		

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01290	Continued From page 11 however, the scope and level remain at l.	01290		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency training and evaluations were completed for one of two employees (unlicensed personnel (ULP)-E), prior to providing direct care. 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	01330		

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	20146	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE	700 NW 2ND AVENUE ROCHESTER, MN 55901

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01330	Continued From page 12 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had a hire date of September 2, 2025, to provide personal care to the licensee's residents. On May 4, 2026, at 2:00 p.m., the surveyor observed ULP-E set up and administer medications to R4. ULP-E's training record lacked the following training required prior to providing services: - documentation requirements for all services provided; - reports of changes in the residents' condition to the supervisor designated by the assisted living provider; - appropriate and safe techniques in personal hygiene and grooming (assigned training not started) - medication, exercise, and treatment reminders; - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the residents On May 6, 2026, at 2:45 p.m., licensed assisted living director (LALD)-B stated a couple of administrative staff shared the role of assigning new hire training and would need to find out what they were using as a tool to assign training. She further stated it was clear that the training assigned was missing required content and it could not be certain other staff had all the	01330		

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01330	Continued From page 13 required training accurately assigned. The licensee's Assisted Living Orientation Training-ULP staff dated June 25, 2025, indicated ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: - Documentation requirements for services provided - Changes of condition - Observation - How and where to report - Appropriate and safe techniques in personal hygiene and grooming; - Commonly used health technology equipment and assistive devices; - Observing, reporting, and documenting resident status; - Basic knowledge of body functioning; - Changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel; and - Recognizing physical, emotional, cognitive and developmental needs of the resident No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
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;	01470		

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01470	Continued From page 14 (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; (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	01470		

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01470	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had a hire date of September 2, 2025, to provide personal care to the licensee's residents. On May 4, 2026, at 2:00 p.m. the surveyor observed ULP-E set up and administer medications to R4.	01470		

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01470	Continued From page 16 ULP-E's record lacked evidence she received orientation to assisted living facility to include the following required content: - an overview of Assisted Living Statutes; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - review of provider's policies and procedures; - handling of resident complaints, reporting of complaints, where to report; - 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 - a review of the types of assisted living services the staff members will be providing and the facility's category of licensure. On May 6, 2026, at 2:45 p.m., licensed assisted living director (LALD)-B stated a couple of administrative staff coordinated the staff assigned training with Educare (the licensee's online training system) and was not certain what tool was used to assign orientation training to ensure all required training topics were covered. LALD-B stated she would need to review this and ensure all staff have received the proper/required training at orientation. The licensee's Assisted Living and Assisted Living with Memory Care Orientation-All Staff policy dated July 1, 2025, indicated All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At minimum, orientation must include the following topics:	01470		

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01470	Continued From page 17 - An overview of Minnesota's assisted living law - An introduction and review of agency policies and procedures related to the provision of assisted living services - Consumer Advocacy Services - Complaint process - Contact information for the Office of Health Facility Complaints - Contact information for the Office of the Ombudsman for long-term care - Contact information for the Office of the Ombudsman for Mental Health and Disabilities No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 18 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01500		

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01500	Continued From page 19 review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (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 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D began providing direct care services on November 5, 2019, for the licensee's residents. On May 5, 2026, at 8:40 a.m., the surveyor observed ULP-D complete a blood sugar check, set up and administer oral medications and insulin to R9. ULP-D's employee record lacked evidence that the employee had successfully completed annual training to include the following required topics: - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to solve problems when working with a resident's challenging	01500		

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01500	Continued From page 20 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 6, 2026, at 2:45 p.m., licensed assisted living director (LALD)-B stated ULP-D's record appeared to lack the required annual training and would review how the trainings were assigned. The licensee's Assisted Living with Memory Care Annual Training policy dated July 1, 2025, indicated All assisted living employees will complete annual education on the following topics: - Infection control techniques used in the home and implementation of infection; - Effective approaches for problem solving when working with challenging behaviors; - Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders; - Review of policies and procedures relating to the provision to assisted living services and how to implement them; and - Principles of person-centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01750	Continued From page 21	01750		
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 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 two unlicensed personnel (ULP-D) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for one of two residents with insulin (R9). Furthermore, the licensee failed to ensure the registered nurse (RN) included written instructions for medication administration for two of two residents (R5, R6) who received as needed (PRN) medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01750		

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01750	Continued From page 22 INSULIN ADMINISTRATION R9 R9 was admitted to the facility on September 23, 2024, with diagnoses including stroke with left sided hemiparesis, seizure disorder, and type 1 diabetes. R9's Service Agreement dated August 15, 2025, indicated R9 received services including medication management/administration. R9's signed prescriber's order dated October 13, 2025, indicated: - Lantus Solostar 100 units/milliliter (u/ml), inject 50 units under the skin every morning; and - Novolog 100 u/ml, inject 6 units under the skin each morning with breakfast, 10 units with lunch, and 10 units with dinner On May 5, 2026, at 9:23 a.m., the surveyor observed ULP-D set up and administer five oral medications and prepare two insulin pens (Lantus and NovoLog) for administration. ULP-D compared the labels of each insulin pen to the information on the electronic medication record (EMAR) and stated R9 received 50 units of Lantus (long acting) insulin, and 6 units of NovoLog (short acting) insulin in the morning. ULP-D dialed each insulin pen to the designated dose, obtained a new needle and alcohol wipes and entered R9's room. ULP-D wiped the rubber tip of each insulin pen and attached a needle to each pen. ULP-D then cleansed two areas of the skin on R9's abdomen and administered each dose of insulin. The licensee failed to ensure the proper procedure was followed for a prefilled insulin pen by priming the new needle with two units of	01750		

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01750	Continued From page 23 insulin prior to dialing to the dose to be administered. On May 5, 2026, at 9:40 a.m., ULP-D stated she was not aware she needed to prime the insulin pen needle prior to administering the prescribed dose. On May 5, 2026, at 10:10 a.m., clinical nurse supervisor (CNS)-C stated all staff passing medications, have been trained on proper insulin pen set up to include priming the new needle with two units of insulin. CNS-C further stated she was surprised ULP-D stated she didn't know she needed to prime the needle as CNS-C had witnessed her doing so in the past. PRN MEDICATION INSTRUCTION R5 R5 was admitted to the facility on August 3, 2023, with diagnoses including dementia and chronic kidney disease. R5's Service Agreement dated May 30, 2025, indicated R5 received services including medication management/administration. R5's signed prescriber's orders dated October 27, 2025, indicated she received scheduled medications including one medication for mild pain, three supplements, one for depression, one for kidney failure/water retention, one for high blood pressure, and one for sleep. Furthermore, R5 received as needed PRN medications including one topical (on the skin) medication for pain, one topical for skin rash, two oral medications for constipation, and one for agitation at night/sleep. R5's medication administration record (MAR)	01750		

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01750	Continued From page 24 dated May 2026, included: -MiraLAX 17 grams (gm), give 17 grams daily as needed for constipation; and -senna-s 8.6/50 milligrams (mg), give one tablet daily (may take up to two times daily) as needed for constipation The licensee failed to indicate in writing which PRN medication for constipation should be used first/second. R6 R6 was admitted to the facility on July 4, 2024, with diagnoses including dementia. R6's Service Agreement dated June 25, 2025, indicated R6 received services including medication management/administration. R6's signed prescriber's orders dated November 13, 2026, January 7, 2026, and January 26, 2026, indicated scheduled medications including one medication for mild pain, one for edema (water retention), one for nerve pain, one for high blood pressure and one supplement. Additionally, the orders indicated PRN medications including two topical medications for pain. R6's MAR dated May 2026, indicated: -diclofenac gel 1%, apply 2 gram (gm) up to three times daily PRN for leg pain -lidocaine patch 5 %, apply one patch for 12 hours as needed for leg pain and to affected area for pain The licensee failed to provide written instructions to direct the ULP which topical pain medication should be used first/second. On May 6, 2026, at 2:30 p.m., CNS-C stated she	01750		

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01750	Continued From page 25 was not aware that when multiple PRN medications were prescribed to manage the same symptoms, that the nurse needed to include written instruction for the ULP to follow. She further stated it made sense to do so and would review each resident MAR to ensure instructions were included. Lantus manufacturer's instructions dated 2022, indicated the user to dial the insulin pen to 2 units of insulin after attaching a new needle to ensure insulin had cleared the needle and the proper dose would be administered. Novolog manufacturer's instructions dated April 2015, indicated to prime the insulin pen with 2 units of insulin after attaching a new needle before dialing to the prescribed dose. The licensee's Insulin Pen Injection Skill dated August 7, 2025, indicated to prepare the insulin pen, remove the pen cap and clean with alcohol swab, connect the needle to the pen, and prime the pen with 2 units of insulin or until insulin comes out of the needle. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated June 25, 2025, indicated the registered nurse (RN) may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed above if the RN has developed written, specific instruction for each resident. No further information was provided.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20146	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE	700 NW 2ND AVENUE ROCHESTER, MN 55901

(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
01750	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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).	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20146	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE	700 NW 2ND AVENUE ROCHESTER, MN 55901

(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
02040	Continued From page 27 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Arbor Terrace
700 NW 2ND AVENUE
Rochester, MN 55901
Olmsted County
Parcel:

Phone:
kberg@samaritanbethany.com

License Info

License: HFID 20146

Risk:
License:
Expires on:
CFPM: Rachael Paddock
CFPM #: 108395; Exp: 9/1/2027

Inspection Info

Report Number: F1038261071
Inspection Type: Full - Single
Date: 5/5/2026 Time: 10:00:33 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-204.112B *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620B Provide permanently mounted temperature measuring device for cold or hot holding equipment used for TCS food.
COMMENT:
INTERNAL TEMPERATURE MEASURING DEVICE IS MISSING IN THE UP RIGHT COOLER IN LOWER SMALL KITCHEN
Comply By: 5/5/2026 Originally Issued On: 5/5/2026

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT:
HAND WASHING SINK IN UPSTAIRS KITCHEN NO SEALED TO THE WALL
Comply By: 5/8/2026 Originally Issued On: 5/5/2026

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 Rochester District Office inspection report number F1038261071 from 5/5/2026

Establishment Representative

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20146016-0	**Date:** May 6, 2026
Facility Name: Arbor Terrace	
Facility Address: 700 NW 2nd Avenue, Rochester, MN 55901	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Two (2) days

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

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: On the second floor, the 1 ½ hour labeled fire door between independent living and assisted living was propped open with a wreath hanger installed over the top of the door. When the wreath hanger was removed, this door did not fully close and positively latch. Fire doors shall be maintained to close and latch automatically after every use, preventing the spread of smoke and fire in the event of an emergency.

3. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments:
   - A keypad lock that required entry of a code to unlock was installed on the marked exit door leading from the secure dementia care unit into the stairwell. During the building tour, building operations specialist (BOS)-G stated this exit door lock was not fail safe and would not unlock with activation of the fire alarm system, fire sprinkler system, or loss of power.
   - During the building tour, the surveyor asked maintenance supervisor (MS)-H if a remote button or switch was installed that would disengage the controlled egress locking system for the building. MS-H stated no.

- Unlocking procedures for the controlled egress locking system were not included in the fire safety and evacuation plan.

4. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3]

   Comments: There were two oxygen cylinders stored on the floor in the closet adjacent to the east exit door for the dementia care unit. These oxygen cylinders were not stored in racks. The licensee stated this was not a designated oxygen storage area and they were not aware these cylinders had been placed inside this closet.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: In the apartments designated as "independent living", which were included in the licensed area, smoke alarms were not installed in resident sleeping rooms.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The provided fire safety and evacuation plan (FSEP) in the emergency binder failed to include evacuation procedures for the individualized unique needs of residents. The licensee stated these procedures were maintained electronically for the assisted living and dementia care residents. These procedures would not be easily accessible to all staff or emergency responders during a fire or similar emergency.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: The safety risk assessment for the property and grounds, dated February 16, 2026, failed to include a mitigation strategy for each hazard identified.