Electronically Delivered

July 14, 2026

Licensee
Fairway View Assisted Living
215 Lundell Avenue
Ortonville, MN 56278

RE: Project Number(s) SL30337016

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.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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.

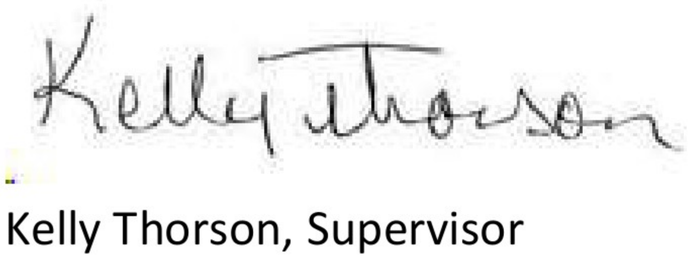
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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: SL30337016-0 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 27 resident(s); 24 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 650		

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0 650	Continued From page 2 a large portion or all of the residents). The findings include: During the entrance conference on June 15, 2026, at 10:57 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-D ULP-D was hired on April 22, 2024, to provide direct care services to residents. On June 15, 2026, at 9:05 a.m., the surveyor observed ULP-D administer scheduled medications to R5. ULP-D's employee record lacked evidence of review of licensee's policies and procedures and review of the types of assisted living services the employee provided and the licensee's scope of license during orientation as well as annual review of the licensee's policies and procedures. ULP-D's employee record also lacked the following competency evaluations: - oxygen; - modified diets; and - CPAP/BIPAP (continuous positive airway pressure/ bilevel positive airway pressure) machines. ULP-E ULP-E was hired on December 11, 2024, to provide direct care services to residents. ULP-E's employee record lacked evidence of review of licensee's policies and procedures and review of the types of assisted living services the employee provided and the licensee's scope of license during orientation as well as annual	0 650		

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0 650	Continued From page 3 review of the licensee's policies and procedures. ULP-D's employee record also lacked the following competency evaluations: - oxygen; - modified diets; and - CPAP/BIPAP machines. On June 16, 2026, at 9:17 a.m., ULP-D stated ULP-D's orientation and training consisted of one on one instruction with clinical nurse supervisor (CNS)-B, review of the licensee's policies, and competency test out prior to working independently. On June 17, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee's policies and UDALSA (Uniform Disclosure of Assisted Living Services and Amenities) was reviewed with all employees during orientation and annual policy review was completed during employee meetings throughout the year. CNS-B further stated documentation to provide evidence of the policy and UDALSA reviews was not completed for all employee files. The licensee's Personnel Records policy dated April 2024, indicated personnel files for each employee contained documentation of the following: - assisted living orientation; and - required training and competency evaluations. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic:	0 650		

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0 650	Continued From page 4 (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 5 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=C	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 6 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 810		

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0 810	Continued From page 7 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

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01440	Continued From page 8 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 had begun working for the licensee for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 15, 2026, at 10:57 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-D ULP-D was hired on April 22, 2024, to provide direct care services to residents. On June 15, 2026, at 9:05 a.m., the surveyor observed ULP-D administer scheduled medications to R5.	01440		

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01440	Continued From page 9 ULP-D's employee record included a document labeled [licensee] Supervisory Visit Notes and marked as ULP-D's 90-day supervision, dated June 12, 2024, which indicated 51 days had passed since ULP-D began performing delegated tasks for the licensee. ULP-E ULP-E was hired on December 11, 2024, to provide direct care services to residents. ULP-E's employee record included a document labeled [licensee] Supervisory Visit Notes and marked as ULP-E's 90-day supervision, dated February 23, 2026, which indicated 439 days had passed since ULP-E began performing delegated tasks for the licensee. ULP-D and ULP-E employee records lacked documentation of an appropriate licensed health professional or registered nurse (RN) supervising ULP-D or ULP-E performing a delegated task within 30 days of the start of the employee providing a delegated task or service. ALDIR/ULP-A, ULP-C, and ULP-D's employee records lacked documentation of an appropriate licensed health professional or registered nurse (RN) supervising ALDIR/ULP-A, ULP-C, or ULP-D performing a delegated task within 30 days of providing a delegated task or service. On June 17, 2026, at 10:47 a.m., CNS-B stated CNS-B was aware of the requirement to complete staff observations within 30 days of being hired and ULP-D and ULP-E's supervision were done late in error and CNS-B was unable to recall a current employee whose 30-day supervision was done within the required time frame.	01440		

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01440	Continued From page 10 The licensee's Personnel Records policy dated April 2024, indicated each employee record included results of supervision observations however it did not address the timeline of those observations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

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01650	Continued From page 11 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R3, R4, and R5). 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: R3 R3 was admitted to the licensee and began receiving assisted living services on April 19, 2026. R3's diagnoses included hypertension (elevated blood pressure), heart disease (disease that affects the structure or function of the heart), Congestive Heart Failure (chronic heart condition causing fluid retention), Chronic Kidney Disease (kidney damage resulting in loss of ability to filter blood properly), and Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing difficulties). R3's Attachment D- Service Plan dated April 19,	01650		

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01650	Continued From page 12 2026, indicated R3 received medication set-up, monthly vital signs, safety checks, and meals. R4 R4 was admitted to the licensee and began receiving assisted living services on May 6, 2025. R4's diagnoses included hypertension, coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), Diabetes Mellitus (chronic condition where the body cannot effectively process food into energy), and macular degeneration (eye disease that blurs the eye's sharp, central vision). R4's Attachment D- Service Plan dated January 28, 2026, indicated R4 received medication management services, bathing set-up, dressing set-up, monthly vital signs, safety checks, and meals R5 R5 was admitted to the licensee and began receiving assisted living services on February 9, 2021. R5's diagnoses included hypertension, gastritis (inflammation, irritation, or swelling of the stomach's protective lining), anxiety, and Osteoarthritis (degenerative joint disease where protective cartilage covering the ends of your bones gradually wears down, causing bones to rub against each other). R5's Attachment D- Service Plan dated February 2, 2026, indicated R5 received oxygen management, nebulizer management, bathing and grooming assistance, medication management, transfer assistance, monthly vital	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01650	Continued From page 13 signs, safety checks, and meals. R3, R4 and R5's service plans lacked the following content: - schedule and methods of monitoring assessments of the resident; and - schedule and methods of monitoring staff providing services. On June 16, 2026, at 11:24 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was unaware the items listed above were required to be included in the resident service plan and that the items listed above were missing from the current service plan templates. CNS-B further stated all current resident records contained service plans built from the same template and were missing the required information. The licensee's Resident Record policy dated January 5, 2026, indicated resident records must include the current and previous resident assessments and service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820		

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	30337	A. BUILDING: _____ B. WING _____	06/17/2026

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FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

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01820	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for two of three residents (R3 and R4) who received medication management services. In addition, the licensee failed to ensure prescriber orders contained all required content for one of three residents (R4). 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 10:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. MISSING ORDERS R3 R3 was admitted to the licensee and began receiving assisted living services on April 19, 2026. R3's diagnoses included hypertension (elevated blood pressure), heart disease (disease that affects the structure or function of the heart), Congestive Heart Failure (chronic heart condition causing fluid retention), Chronic Kidney Disease (kidney damage resulting in loss of ability to filter blood properly), and Chronic Obstructive	01820		

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FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

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01820	Continued From page 15 Pulmonary Disease (lung disease causing restricted airflow and breathing difficulties). R3's Attachment D- Service Plan dated April 19, 2026, indicated R3 received medication set-up, monthly vital signs, safety checks, and meals. R3's Home Health Certification and Plan of Care (provider orders) dated April 21, 2026, indicated R3 was prescribed Hyland Homeopathic Restful Legs, take one tablet at bedtime. R3's Medication Administration Record (medication set-up document) lacked including Hyland Homeopathic Restful Legs as ordered. On June 16, 2026, at 1:59 p.m., CNS-B stated when R3 ran out of R3's personal supply of the above medication, R3 declined wanting or needing to take the supplement any longer however, CNS-B neglected to obtain an order to discontinue the medication from R3's provider. R4 R4 was admitted to the licensee and began receiving assisted living services on May 6, 2025. R4's diagnoses included hypertension, coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), Diabetes Mellitus (chronic condition where the body cannot effectively process food into energy), and macular degeneration (eye disease that blurs the eye's sharp, central vision). R4's Attachment D- Service Plan dated January 28, 2026, indicated R4 received medication management services, bathing set-up, dressing set-up, monthly vital signs, safety checks, and	01820		

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01820	Continued From page 16 meals On June 16, 2026, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer scheduled medications to R4. R4's Home Health Certification and Plan of Care (provider orders) dated April 30, 2026, included the following: - allopurinol (used to treat gout) 300 milligrams (mg) take one daily; - fish oil (supplement) 1200 take twice a day; - multivitamin (supplement) take one daily; and - vitamin D (supplement) 2000 international units (IU) take one daily. R4's Medication Administration Record (MAR) dated June 1, 2026, through June 31, 2026, lacked including the above-mentioned medications as ordered. R4's MAR also included Bio Freeze- apply to affected area as needed, however, lacked a complete order for the medication. On June 17, 2026, at 10:01 a.m., CNS-B stated the above medications were included on R4's medication orders however, R4 declined wanting to continue the medication after R4 was admitted. CNS-B further stated CNS-B neglected to remove the medications from R4's medication order renewal form or request an order to discontinue the above medications rather, CNS-B only removed them from R4's MAR. INCOMPLETE ORDERS R4's Home Health Certification and Plan of Care (provider orders) dated April 30, 2026, included the following order: - Voltaren Gel for pain twice times (sic) a day.	01820		

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01820	Continued From page 17 R4's record lacked a prescriber order which included the dose of Voltaren gel to be applied. On June 17, 2026, at 10:17 a.m., CNS-B stated complete medication orders included the medication name, dose, route, and specific instructions if needed. CNS-B further stated R4's Voltaren gel order was incomplete, and CNS-B missed it in error. The licensee's Medication Management Services policy dated January 17, 2024, indicated the assisted living RN (registered nurse) required an order for all medications managed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for one of three residents (R4). This practice resulted in a level two violation (a	01880		

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01880	Continued From page 18 violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 15, 2026, at 10:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R4 was admitted to the licensee and began receiving assisted living services on May 6, 2025. R4's diagnoses included hypertension, coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), Diabetes Mellitus (chronic condition where the body cannot effectively process food into energy), and macular degeneration (eye disease that blurs the eye's sharp, central vision). R4's Attachment D- Service Plan dated January 28, 2026, indicated R4 received medication management services, bathing set-up, dressing set-up, monthly vital signs, safety checks, and meals R4's Attachment D1- Individualized Medication Management Plan dated January 16, 2026, indicated licensee staff provided medication administration services however the column to select whether medications were stored securely or not within the apartment was not addressed.	01880		

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01880	Continued From page 19 R4's Resident Care Plans 2026 dated March 13, 2026, indicated under 'Focus Medications' the following: - Intervention: Self-Administration: resident is indepentadnt (sic) with self-administration of medications (some OTC (over the counter) meds (medication)); and - Intervention: Intervene a ion (sic) Administration: Medication trained staff to managed (sic) medication storage and security (using a locked cabnit (sic) in resident room). On June 16, 2026, at 7:21 a.m., the surveyor observed the following on R4's chair-side table: - Bio Freeze (pain relief for muscles and joint discomfort) roll-on, partial bottle; and - Extra Strength Pain Relief PM (acetaminophen 500 milligrams (mg)/diphenhydramine 25 mg), quantity four tablets, expired August 2024. On June 16, 2026, at 0722, R4 stated R4's family provided the above medications and R4 used them when R4 felt the medication was needed. On June 16, 2026, at 10:22 a.m., CNS-B stated CNS-B was unaware R4 kept the above medications in R4's apartment thus, CNS-B hadn't requested a provider order, assessed specifically for self-administration, or monitored for expiration. The licensee's Medication Management policy dated January 17, 2024, indicated the RN (registered nurse) determined which medication management services were provided and was responsible for implementation of the licensee's medication management policies. No further information was provided.	01880		

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01880	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 monitor for expired medication for two of three residents (R4 and R5) and facility shared supply. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 15, 2026, at 10:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. On June 16, 2026, at 7:14 a.m., the surveyor	01890		

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01890	Continued From page 21 observed R4's secure medication supply with unlicensed personnel (ULP)-C and observed the following expired medications: - meclizine 25 milligrams (mg), unknown number of pills remained, expired February 27, 2026; - simethicone 125 mg, 14 tablets remained, expired February 2026; - vaporizing chest rub, partial container, expired July 2019; and - metoprolol succinate (treats high blood pressure) ER (extended release) 25 mg, unknown number of tablets remained, expired April 14, 2026. On June 16, 2026, at 9:11 a.m., the surveyor observed R5's secure medication supply with ULP-D and observed the following expired medications: - miconazole (treats fungal and yeast infections) cream, partial tube remained, expired March 2023; - loperamide (anti-diarrheal) 2 mg, 18 tablets remained, expired February 2026; - loperamide 2 mg, 18 tablets remained, expired March 2026; - sodium chloride 7% (percent) vials, 55 vials remained, expired December 31, 2025; - acetaminophen ER 650 mg, unknown number of tablets remained, expired December 2024; and - tramadol (pain management) 50 mg, 10 tablets remained, expired April 9, 2026. On June 16, 2026, at 7:51 a.m., the surveyor observed the ULP office storage with ULP-C and observed the following: - facility supply of Narcan (opioid overdose reversal), two inhalation doses, expired November 2025. On June 16, 2026, at 9:17 a.m., ULP-D stated	01890		

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01890	Continued From page 22 CNS-B audited medication supplies for expiration dates however ULP-D was unsure how often the audits were completed. On June 16, 2026, at 2:01 p.m., CNS-B stated CNS-B audited medication supplies for residents receiving medication management services and the facility supplies monthly. CNS-B further stated the above expired medications were missed in error. The licensee's Disposition Meds (medication) policy dated April 9, 2021, indicated medications stored within a resident's private living space were treated as household waste and destroyed by flushing into the sewer system or mixing with coffee grounds. The policy further indicated medications stored outside a resident's private living space were disposed of according to Minnesota Pollution Control Agency guidelines. The policy also indicated documentation of medication disposition included the date of destruction, name and quantity of the medication, prescription number, and signature of the employee who completed the destruction as well as the employee who witnessed the destruction and placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Fairway View Assisted Living
215 LUNDELL AVENUE
ortonville, MN 56278
big stone
Parcel:

Phone:

License Info

License: HFID 30337

Risk:
License:
Expires on:
CFPM: Lynelle R Dwyer
CFPM #: 1229; Exp: 8/4/2026

Inspection Info

Report Number: F7935261068
Inspection Type: Full - Single
Date: 6/15/2026 Time: 11:36:48 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Establishment is a serving kitchen only.

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 Fergus Falls District Office inspection report number F7935261068 from 6/15/2026

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Fairway View Assisted Living
ortonville
County/Group: big stone

Inspection Info

Report Number: F7935261068
Inspection Type: Full
Date: 6/15/2026
Time: 11:36:48 AM

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Fairway View Assisted Living
ortonville
County/Group: big stone

Inspection Info

Report Number: F7935261068
Inspection Type: Full
Date: 6/15/2026
Time: 11:36:48 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30337016	**Date:** 6/16/2026
Facility Name: Fairway View Assisted Living	
Facility Address: 215 Lindell Ave, Ortonville, MN 56278	

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire extinguisher located in the elevator room did not have a current annual service tag. Fire extinguishers should receive annual inspections by a licensed contractor and monthly inspections by facility staff.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 1; 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 fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensee failed to provide specific fire protection procedures for residents to the surveyor during the survey. The FSEP did not include specific policies for resident procedures during evacuation and only contained general information regarding fire safety. Site-specific plans should be included for residents in the FSEP.