



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2026

Licensee

Cannon Falls Assisted Living

900 Main Street West

Cannon Falls, MN 55009

RE: Project Number(s) SL26730016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

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.

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
(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: SL26730016-0 On August 17, 2026, through August 19, 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 108 residents; 73 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during blood sugar checks by two of two employees (unlicensed personnel (ULP)-C and ULP-D). This had the potential to affect all residents receiving blood sugar checks. 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	0 510			

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: On August 17, 2026, at 12:00 p.m., the surveyor observed ULP-C put gloves on, prepare R2's Novolog insulin pen, gather R2's diabetic supplies and bring them to R2. ULP-C prepared R2's glucometer (device that measures the concentration of glucose (sugar) in a person's blood), wiped R2's right pointer finger with an alcohol prep pad, pricked R2's fingertip with a lancet, squeezed R2's finger and placed a drop of blood onto the test strip. ULP-C then administered R2's insulin. ULP-C brought R2's blood sugar supplies and insulin pen back to the medication cart, disposed of the test strip with blood on it, removed the needle from the insulin pen and documented the blood sugar results and insulin administration. ULP-C removed and disposed of her gloves and began to prepare medications for another resident. ULP-C did not remove her gloves between tasks and did not perform hand hygiene after removing gloves. On August 17, 2026, at 12:07 p.m., the surveyor observed ULP-C put gloves on, gather R1's Novolog insulin pen and diabetic supplies. ULP-C did not have any needles to attach to R1's insulin pen so she went to the medication room to get more needles. ULP-C returned to the medication cart, prepared R1's Novolog insulin, gathered diabetic supplies and brought them to R1. ULP-C checked R1's blood sugar via Libre sensor (device that continuously monitors blood sugar) and then administered R1's insulin into his abdomen. ULP-C brought R1's Libre sensor and insulin pen back to the medication cart, disposed of the insulin pen needle, documented R1's blood sugar result and administration of insulin. ULP-C	0 510			

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0 510	Continued From page 5 removed and disposed of her gloves. ULP-C did not remove gloves between tasks and did not perform hand hygiene after removing her gloves. On August 18, 2026, at 8:31 a.m., the surveyor observed ULP-D prepare R2's medication, Novolog and Lantus insulin pens, gathered R2's diabetic supplies and brought them to R2. ULP-D put gloves on, prepared R2's glucometer, wiped R2's right pointer finger with an alcohol prep pad, pricked R2's fingertip with a lancet, squeezed R2's finger and placed a drop of blood onto the test strip. ULP-D then administered R2's insulins and administered R2's medications. ULP-D brought R2's blood sugar supplies and insulin pens back to the medication cart, disposed of the test strip with blood on it, removed the needles from the insulin pens, documented the blood sugar results insulin administration, and medication administration. ULP-D removed and disposed of her gloves and performed hand hygiene. ULP-D did not remove or change gloves in between tasks. On August 19, 2026, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated staff were expected to wear gloves when performing any task that involved blood and bodily fluids. CNS-B stated the staff were also expected to perform hand hygiene between tasks and in between resident cares. The licensee's undated Gloves policy indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. The licensee's undated, Hand-Washing policy indicated proper hand-washing techniques should be used to protect the spread of infection. Hand	0 510			

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0 510	Continued From page 6 washing shall be completed: -before, during, and after preparing food -before eating food -before and after caring for someone who is sick -before and after treating a cut or wound -after using the toilet -after changing diapers or cleaning up after someone who has used the toilet -after blowing your nose, coughing, or sneezing -after touching an animal or animal waste -after handling pet food or pet treats -after touching garbage No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include	0 630			

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0 630	Continued From page 7 the required content for four of four residents (R1, R2, R3, and 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 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: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene, dressing, catheter care, bathing, blood sugar checks, medication administration. R1's IAPP (found within the comprehensive nursing assessment) dated July 30, 2026, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - the resident's risk of abusing other vulnerable adults. - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026,	0 630			

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0 630	Continued From page 8 indicated R2 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R2's IAPP (found within the comprehensive nursing assessment) dated June 4, 2026, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - the resident's risk of abusing other vulnerable adults. - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R3's IAPP (found within the comprehensive nursing assessment) dated May 19, 2026, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - the resident's risk of abusing other vulnerable adults. - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4 R4 was admitted on May 26, 2026, with diagnoses that included dementia. R4's service plan dated May 26, 2026, indicated	0 630			

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0 630	Continued From page 9 R4 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R4's IAPP (found within the comprehensive nursing assessment) dated June 9, 2026, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - the resident's risk of abusing other vulnerable adults. - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 19, 2026, at 11:16 a.m., clinical nurse supervisor (CNS)-B stated the regional nurse had notified the licensee that the IAPPs within the comprehensive nursing assessment did not have the required content built into the assessment. CNS-B stated the regional nurse was working on updating the electronic health record system to include options that would meet the requirements of the IAPP for all residents. The licensee's undated, Individual Abuse Prevention Plan policy indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: -other vulnerable adults -the person's risk of abusing other vulnerable adults, and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630			

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0 630	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
0 730	Continued From page 11 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required content in a discharge summary for one of one discharged resident (R6). 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: R6 was admitted to the licensee on June 1, 2019, and discharged on June 14, 2026. R6's record lacked a discharge summary to include the following required content:	0 730			

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0 730	Continued From page 12 -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On August 19, 2026, at 11:29 a.m., clinical nurse supervisor (CNS)-B stated R6's record lacked a discharge summary to include the required content as listed above. The licensee's undated, Resident Record-Information and Content policy indicated resident records would include a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			

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0 775	Continued From page 13	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440			

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01440	Continued From page 14 (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 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-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	01440			

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01440	Continued From page 15 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 was hired on March 10, 2026, to provide direct care and services to the licensee's residents. On August 18, 2026, at 8:31 a.m., the surveyor observed unlicensed ULP-D administer medications to R2. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On August 19, 2026, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated ULP-D's employee record lacked evidence of a 30-day supervision of a delegated task by the RN. The licensee's undated, Supervision of Staff-Delegated Services policy indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			

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01620	Continued From page 16	01620			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620			

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01620	Continued From page 17 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for three of four residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene,	01620			

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01620	Continued From page 18 dressing, catheter care, bathing, blood sugar checks, and medication administration. R1's ongoing nursing assessments dated April 29, 2026, and July 30, 2026, were reviewed. The July 30, 2026, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026, indicated R2 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R2's ongoing nursing assessments dated November 7, 2025, February 13, 2026, and June 4, 2026, were reviewed. The February 13, 2026, assessment was completed 98 days after the date of the previous assessment and the June 4, 2026, assessment was completed 111 days after the date of the previous assessment, thus both exceeded 90 calendar days. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R3's ongoing nursing assessments dated November 17, 2025, February 18, 2026, May 19, 2026, were reviewed. The February 18, 2026, was completed 93 days after the date of the	01620			

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01620	Continued From page 19 previous assessment, thus exceeding 90 calendar days. R3's record lacked an ongoing nurse assessment which was due by August 17, 2026. On August 19, 2026, at 11:36 a.m., clinical nurse supervisor (CNS)-B stated R1, R2 and R3's assessments were not completed within the required timeframe as noted above. CNS-B stated they had fallen behind on resident assessments but were working on getting caught up and have a plan going forward to ensure all assessments are completed timely. The licensee's undated, Assessments, Reviews, and Monitoring policy indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessments and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640			

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01640	Continued From page 20 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for four of four residents (R1, R2, R3, and 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: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes.	01640			

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01640	Continued From page 21 R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene, dressing, catheter care, bathing, blood sugar checks, and medication administration. On August 17, 2026, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar via Free Style Libre sensor (device that continuously monitors blood sugar). R1's signed prescriber orders dated August 5, 2026, included the following: -Free Style Libre; use as directed, change every 14 days R1's medication administration record (MAR) dated August 2026, included the following: -Free Style Libre Sensor: change sensor every 14 days R1's service plan did not include Libre sensor management. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026, indicated R2 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. On August 18, 2026, at 8:31 a.m., the surveyor observed ULP-D check R2's blood sugar and pulse. R2's record lacked prescriber orders for blood sugar checks and daily pulse checks.	01640			

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01640	Continued From page 22 R2's MAR dated August 2026, included the following: -Blood sugar checks four times a day -metoprolol succinate 50 milligrams (mg); give one capsule by mouth one time a day. Check pulse prior to administration, if pulse is less than 50 hold. R2's service plan did not include blood sugar checks or daily pulse checks. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing and medication administration. On August 17, 2026, at 11:51 a.m., the surveyor observed R3 wearing compression stockings. R3's signed prescriber orders dated May 5, 2025, included the following: -knee-high compression stockings. Put on in the morning upon waking and take off at bedtime. R3's documentation survey report dated August 2026, included the following: -compression socks on in the a.m. (morning) and off in p.m. (evening). Wash in the sink with soap and water at night, ring out well, and hang to dry every night. R3's service plan did not include compression stockings. R4 R4 was admitted on May 26, 2026, with	01640			

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01640	Continued From page 23 diagnoses that included dementia. R4's service plan dated May 26, 2026, indicated R4 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R4's record lacked prescriber orders for compression stockings. R4's documentation survey report dated August 2026, included the following: -Apply compression stockings to each leg every morning before the resident gets out of bed or as early in the day as possible. Remove the compression stockings at bedtime. R4's service plan did not include compression stockings. On August 19, 2026, at 11:43 a.m., clinical nurse supervisor (CNS)-B reviewed R1's service plan and stated it did not include Libre sensor management. CNS-B reviewed R2's service plan and stated it did not include blood sugar checks and daily pulse checks. CNS-B reviewed R3's service plan and stated it did not include compression stockings. CNS-B reviewed R4's service plan and stated it did not include compression stockings. CNS-B stated she would update R1, R2, R3 and R4's service plan to include the missing services. The licensee's undated, Service Plan policy indicated all residents receiving assisted living services will have a service plan in place. Service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided.	01640			

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01640	Continued From page 24	01640			
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 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 interview and record review, the	01650			

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01650	Continued From page 25 licensee failed to ensure the service plan included all required content for four of four residents (R1, R2, R3, and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene, dressing, catheter care, bathing, blood sugar checks, and medication administration. R1's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and the circumstances in which	01650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01650	Continued From page 26 emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026, indicated R2 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R2's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated	01650			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01650	Continued From page 27 R3 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R3's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 R4 was admitted on May 26, 2026, with diagnoses that included dementia. R4's service plan dated May 26, 2026, indicated R4 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R4's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and	01650			

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01650	Continued From page 28 - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On August 19, 2026, at 11:47 a.m., licensed assisted living director (LALD)-A stated the licensee was aware that the current service plan format did not include the required content as listed above. LALD-A stated the licensee was working with the electronic health record system to update the service plan format to meet the requirements. The licensee's undated, Service Plan policy indicated the service plan would include following: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing the services e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes:	01650			

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01650	Continued From page 29 i. Actions the facility will take if scheduled services cannot be provided ii. Information regarding how the resident can contact the facility iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any- including circumstances when emergency medication services are not to be summoned No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to	01700			

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01700	Continued From page 30 address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for two of two residents (R1 and R4) prior to providing medication management 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: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. On August 18, 2026, at 8:23 a.m., the surveyor	01700			

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01700	Continued From page 31 observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated April 15, 2026, indicated R1 received services to include medication administration. R1's medication administration record dated April 2026, indicated R1 received the following medication on April 15, 202: -atorvastatin calcium 40 milligrams (mg); give one tablet by mouth at bedtime (cholesterol) -cholecalciferol 1,000 units; give one tablet by mouth one time a day (supplement) -finasteride 5 mg; give one table by mouth in the morning (prostate) -hydrochlorothiazide 25 mg; give one tablet by mouth in the morning (diuretic) -K-Tab 20 milliequivalent (meq); give one tablet by mouth one time a day (supplement) -Lantus insulin 100 units/milliliter (ml): Inject 10 units subcutaneously at bedtime (diabetes) -losartan potassium 25 mg; give one tablet by mouth one time a day (blood pressure) -pantoprazole sodium 40 mg; give one tablet by mouth in the morning (acid reflux) -rivaroxaban 20 mg; give one tablet by mouth in the evening (blood thinner) -Vitamin B12 1,000 micrograms (mcg); give one tablet by mouth in the morning (supplement) -Vitron-C 65-125 mg; give one tablet by mouth in the morning (supplement) -Benefiber; give one packet by mouth two times a day (digestive health) -Lactobacillus; give one tablet by mouth two times a day (probiotic) -methenamine hippurate 1 gram; give one tablet by mouth two times a day (urinary tract preventative) -Insulin Aspart 100 units/ml; inject 10 units	01700			

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01700	Continued From page 32 subcutaneously three times a day (diabetes) R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, R1's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R4 R4 was admitted on May 26, 2026, with diagnoses that included dementia. On August 18, 2026, at 7:55 a.m., the surveyor observed ULP-D administer medications to R4. R4's service plan dated May 26, 2026, indicated R4 received services to include medication administration. R4's MAR dated May 2026, indicated R4 received the following medication on the evening of May 26, 2026: -melatonin 3 mg; give one tablet by mouth at bedtime (sleep) R4's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, R4's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications.	01700			

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01700	Continued From page 33 On August 19, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-B stated a face-to-face medication assessment was completed upon admission; however, after a review of R1 and R4's record, CNS-B stated she was unable to locate evidence of the face-to-face medication assessment had been completed for both R1 and R4. The licensee's undated, Medication Management-Assessment, Monitoring and Reassessment policy indicated the "[Licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. Also, included "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or	01700			

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01700	Continued From page 34 other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment at least annually for two of two residents (R2 and R3) who received medication management 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).	01710			

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01710	Continued From page 35 The findings include: R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. On August 18, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's service plan dated February 12, 2026, indicated R2 received services to include medication administration. R2's individualized medication management plan dated June 4, 2026, indicated a face-to-face review of medications was completed by provider and nursing staff on a annual basis and as needed. However, it does not include the date of when the annual reassessment was completed. R2's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. On August 18, 2026, at 8:50 a.m., the surveyor observed ULP-D administer medications to R3. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene,	01710			

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01710	Continued From page 36 toileting, dressing, bathing, and medication administration. R3's individualized medication management plan dated May 28, 2026, indicated a face-to-face review of medications was conducted on August 13, 2025. R3's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On August 19, 2026, at 11: 55 a.m., clinical nurse supervisor (CNS)-B reviewed R2's record and stated it lacked documentation of when the annual medication assessment was completed. CNS-B reviewed R3's record and stated it lacked documentation that an annual medication assessment occurred after the August 13, 2025, medication assessment was completed. The licensee's undated, Medication Management-Assessment, Monitoring and Reassessment policy indicated the "[Licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. Also, included "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include	01710			

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01710	Continued From page 37 indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730			

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01730	Continued From page 38 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R2, R3, and R4).	01730			

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01730	Continued From page 39 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 August 17, 2026, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated resident medications were stored in medication carts and overflow medications were stored in centrally in the medication room. CNS-B stated medications requiring refrigeration were stored in a locked refrigerator in the medication room. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. On August 18, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-D remove one Novolog insulin pen from the locked refrigerator in the medication room, prepare the insulin and administer it to R2. R2's service plan dated February 12, 2026, indicated R2 received services to include medication administration. R2's medication administration record (MAR) dated August 2026, included the following insulin orders: -Novolog Flexpen 100 units/milliliter (ml); inject 3	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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01730	Continued From page 40 units subcutaneously three times a day (diabetes) -Lantus insulin 100 units/ml; inject 17 units subcutaneously in the morning (diabetes) -Novolog Flexpen 100 units/ml; inject two units subcutaneously as needed for blood sugars greater than 350 R2's individualized medication management plan dated June 4, 2026, indicated the following: -Medications kept in locked medication cart and/or locked medication room R2's medication management plan did not include refrigeration storage for R2's insulin. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. On August 18, 2026, at 8:50 a.m., the surveyor observed ULP-D prepare and administer R3's medication. During the preparation of medications, ULP-D removed one multivitamin from a bottle and stated R3's family supplied the vitamin and the rest of R3's medications were provided from the pharmacy. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing and medication administration. R3's individualized medication management plan dated May 28, 2026, indicated the facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. R3's medication plan did not include that R3's family ordered/supplied R3's multivitamin.	01730			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01730	Continued From page 41 R4 R4 was admitted on May 26, 2026, with diagnoses that included dementia. On August 18, 2026, at 7:55 a.m., the surveyor observed ULP-D prepare and administer R4's medication. While preparing R4's medications ULP-D could not locate a medication (escitalopram) in the medication cart. ULP-D went to the medication room to obtain the medication from R4's medication bin which contained overflow of R4's medications. R4's service plan dated May 26, 2026, indicated R4 received services to include medication administration. R4's individualized medication management plan dated May 26, 2026, indicated the following: -medications are stored in a locked medication cart R4's medication plan did not include central storage of medications in the medication room. On August 19, 2026, at 11:58 a.m., CNS-B stated R2's medication plan did not include refrigeration for insulin. CNS-B stated R3's medication plan did not include R3's family supplied a multivitamin. CNS-B stated R4's medication plan did not include central storage for medications. The licensee's undated, Medication Management Individualized Plan policy indicated the facility will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided	01730			

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01730	Continued From page 42 b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medications supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management task that may be delegated to unlicensed personnel f. procedures for staff notifying an RN or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reaction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760			

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01760	Continued From page 43 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber's orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on July 12, 2024, with diagnoses that included diabetes. On August 18, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-D check R2's blood sugar and administer Novolog insulin. R2's service plan dated February 12, 2026, indicated R2 received services to include medication administration. R2's signed prescriber orders included the following: -Novolog Flexpen 100 units/milliliter (ml); inject 3	01760			

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01760	Continued From page 44 units subcutaneously three times a day (diabetes), order dated July 8, 2026; -Novolog Flexpen 100 units/ml; inject two units subcutaneously as needed for blood sugars greater than 350, order dated July 9, 2026 R2's Blood Sugar report dated July 8, 2026, through August 19, 2026, included the following: -On July 13, 2026, R2's blood sugar was 381 -On July 14, 2026, R2's blood sugar was 461 -On July 17, 2026, R2's blood sugar was 454 R2's MAR dated August 2026, indicated R2 received Novolog 3 units subcutaneously three times a day. R2's PRN (as needed) MAR dated August 2026, included an order for Novolog flexpen 100 units/ml; inject two units subcutaneously as needed for blood sugars greater than 350. However, it indicated R2 had not received this medication on the dates listed above when R2's blood sugar was greater than 350. On August 19, 2026, at 11:59 a.m., clinical nurse supervisor (CNS)-B reviewed R2's MAR and blood sugar report and stated R2 had not received the PRN Novolog as ordered. The licensee's undated, Medication and Treatment Orders policy indicated current, authorized prescriber orders for medication or treatments administered by the staff are kept on file in the residents' records. It further indicated the residents MAR would be audited regularly by licensed nurse or designee for documentation compliance. No further information provided.	01760			

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01760	Continued From page 45	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R6). 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	01910			

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01910	Continued From page 46 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: R6 was admitted to the licensee on June 1, 2019, and discharged on June 14, 2026. R6's medication administration record (MAR) dated June 2026, included the following medications: -Lidocaine External Pat 5%; Apply to lower back topically in the morning for general pain. Remove at bedtime. -metoprolol succinate 25 milligrams (mg); give 25 mg by mouth in the morning (blood pressure) -Multi-vitamin; give one tablet by mouth every morning (supplement) -Nystatin Powder 1000,000 units/gram (g); Apply to groin folds/testicles topically in the morning (rash) -potassium chloride 20 milliequivalent (meq); give one tablet by mouth in the morning (supplement) -sertraline 100 mg; give one- and one-half tablet by mouth in the morning (depression) -simvastatin 40 mg; give 40 mg by mouth at bedtime (cholesterol) -torsemide 20 mg; give 20 mg by mouth in the morning (diuretic) -Trulicity 3 mg/0.5 milliliter (ml); Inject one dose subcutaneously one time a week (diabetes) -Vitron-C 65-125 mg; give one tablet by mouth in the morning (supplement) -Apixaban 5 mg; give 5 mg by mouth two times a day (blood thinner) -Basaglar Kwikpen 100 units/ml; inject 12 units subcutaneously two times a day (diabetes) -Preservision capsules; give one capsule by	01910			

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01910	Continued From page 47 mouth two times a day (supplement) -acetaminophen 500 mg; give 1,000 mg by mouth three times a day (pain) -Novolog Flexpen 100 units/ml; inject 10 units subcutaneously with meals (diabetes) -diclofenac sodium gel 1%; apply to back/sore muscles topically every six hours as needed (pain) -guaifenesin 600 mg; give one tablet by mouth every 12 hours as needed for cough/congestion -loperamide 2 mg; give one capsule by mouth every six hours as needed for diarrhea -Metamucil powder; give one packet by mouth as needed for constipation -sennosides-docusate sodium 8.6-50 mg; give one tablet by mouth every 12 hours as needed for constipation -Tramadol 50 mg; give 15 mg by mouth every six hours as needed for pain R6's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 19, 2026, at 12:02 p.m., registered nurse (RN)-E stated R6's record lacked a medication disposition record with the required content as listed above. RN-E stated R6's medications were sent with R6's family upon R6's discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01940	Continued From page 48	01940			
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management	01940			

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01940	Continued From page 49 plan to include all required content for three of four residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene, dressing, catheter care, bathing, blood sugar checks, medication administration. On August 17, 2026, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar via Free Style Libre sensor (device that continuously monitors blood sugar). R1's signed prescriber orders dated August 5, 2026, included the following: -Free Style Libre; use as directed, change every 14 days R1's medication administration record (MAR) dated August 2026, included the following: -Free Style Libre Sensor: change sensor every 14 days	01940			

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01940	Continued From page 50 R1's service plan did not include Libre sensor management. R1's individualized treatment or therapy management plan dated July 30, 2026, indicated R1 received the following treatment services: -blood glucose monitoring -catheter care -vital signs -weight monitoring R1's individualized treatment plan did not include the following required content: -statement of the type of services that will be provided (Libre sensor management) R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026, indicated R2 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. On August 18, 2026, at 8:31 a.m., the surveyor observed ULP-D check R2's blood sugar and pulse. R2's record lacked prescriber orders for blood sugar checks and daily pulse checks. R2's MAR dated August 2026, included the following: -Blood sugar checks four times a day -metoprolol succinate 50 milligrams (mg); give one capsule by mouth one time a day. Check pulse prior to administration, if pulse is less than 50 hold.	01940			

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01940	Continued From page 51 R2's service plan did not include blood sugar checks or daily pulse checks. R2's individualized treatment or therapy management plan dated June 4, 2026, indicated R2 received the following treatment services: -vital signs -weight monitoring R2's individualized treatment plan did not include the following required content: -statement of the type of services that will be provided (blood sugar checks, daily pulse checks) R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. On August 17, 2026, at 11:51 a.m., the surveyor observed R3 wearing compression stockings. R3's signed prescriber orders dated May 5, 2025, included the following: -knee-high compression stockings. Put on in the morning upon waking and take off at bedtime. R3's documentation survey report dated August 2026, included the following: -compression socks on in the a.m. (morning) and off in p.m. (evening). Wash in the sink with soap and water at night, ring out well, and hang to dry every night. R3's service plan did not include compression stockings.	01940			

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01940	Continued From page 52 R3's individualized treatment or therapy management plan dated May 18, 2026, indicated R3 received the following treatment services: -vital signs -weight monitoring R3's individualized treatment plan did not include the following required content: -statement of the type of services that will be provided (compression stockings) On August 19, 2026, at 12:10 p.m., clinical nurse supervisor (CNS)-B reviewed R1, R2, and R3's treatment plans and stated the vital signs and weight monitoring were for the monthly vital signs that all residents received. CNS-B stated R1's treatment plan did not include Libre sensor management, which was changed every two weeks. CNS-B stated R2's treatment plan did not include blood sugar checks and daily pulse checks. CNS-B stated R3's treatment plan did not include compression stockings. The licensee's undated, Treatment and Therapy Management Plan policy indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that will be provided -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy task that will be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 53 services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications or adverse reactions The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for three of four residents (R1, R2, and R3) receiving treatments. 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	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
(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	
01970	Continued From page 54 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: R1 R1 was admitted on April 15, 2026, with diagnoses that included diabetes. R1's service plan dated April 15, 2026, indicated R1 received services to include personal hygiene, dressing, catheter care, bathing, blood sugar checks, and medication administration. On August 17, 2026, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar via Free Style Libre sensor (device that continuously monitors blood sugar). R1's medication administration record (MAR) dated August 2026, included the following: -Please check blood sugar four times daily by reading Libre sensor R1's record lacked signed prescriber orders for four times a day blood sugar checks. R2 R2 was admitted on July 12, 2024, with diagnoses that included diabetes. R2's service plan dated February 12, 2026, indicated R2 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R2's service plan did	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
01970	Continued From page 55 not include blood sugar checks or daily pulse checks. On August 18, 2026, at 8:31 a.m., the surveyor observed ULP-D check R2's blood sugar and pulse. R2's record lacked prescriber orders for blood sugar checks and daily pulse checks. R2's MAR dated August 2026, included the following: -Blood sugar checks four times a day -metoprolol succinate 50 milligrams (mg); give one capsule by mouth one time a day. Check pulse prior to administration, if pulse is less than 50 hold. R2's record contained signed prescriber orders dated August 18, 2026, for blood sugar checks four times a day and PRN (as needed); however, the order was obtained after the start of survey. R1's record lacked signed prescriber orders for daily pulse checks. R3 R3 was admitted on February 12, 2025, with diagnoses that included dementia. R3's service plan dated May 18, 2026, indicated R3 received services to include personal hygiene, toileting, dressing, bathing, and medication administration. R3's service plan did not include compression stockings. On August 17, 2026, at 11:51 a.m., the surveyor observed R3 wearing compression stockings. R3's signed prescriber orders dated May 5, 2025, included the following:	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
01970	Continued From page 56 -knee-high compression stockings. Put on in the morning upon waking and take off at bedtime. R3's documentation survey report dated August 2026, included the following: -compression socks on in the a.m. (morning) and off in p.m. (evening). Wash in the sink with soap and water at night, wring out well, and hang to dry every night. R3's signed prescriber orders dated May 5, 2025, included the following: -compression stockings; put on in the morning upon waking and take off at bedtime R3's record did not include a current order within the past 12 months for compression stockings. On August 19, 2026, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated R1's record lacked signed prescriber orders for blood sugar checks. CNS-B stated R2's record lacked signed prescriber orders for daily pulse checks and the order for blood sugar checks was obtained after the surveyor requested the order. CNS-B stated R3's record lacked updated orders for compression stockings. The licensee's undated, Medication and Treatment Orders policy indicated current, authorized prescriber orders for medication or treatments administered by the staff are kept on file in the residents' records. The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
01970	Continued From page 57	01970			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02040 SS=F	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
(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 58 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 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

Page: 1

Establishment Info

CANNON FALLS ASSISTED LIVING
900 Main Street W
Cannon Falls, MN 55009
Goodhue County
Parcel:

Phone:

License Info

License: HFID 26730

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8074261080
Inspection Type: Full - Single
Date: 8/18/2026 Time: 2:22:07 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: Servesafe certificate obtained but no state CFPM. <https://www.health.state.mn.us/communities/environment/food/cfpm/index.html>

us/communities/environment/food/cfpm/index.html

Comply By: 8/18/2026 Originally Issued On: 8/18/2026

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: Milk on ice during service 49 degrees. Keep refrigerated or use pitcher that is discarded after service.

Comply By: 8/18/2026 Originally Issued On: 8/18/2026

! New Order: 3-500D Microbial Control: disposition of food

3-501.18A Priority Level: Priority 1 CFP#: 23

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: Turkey dated 8/11 discarded.

Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: Thermometer missing from upright in memory care.

Comply By: 8/18/2026 Originally Issued On: 8/18/2026

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 F8074261080 from 8/18/2026

Establishment Representative

Andrea Kieffer,
Public Health Sanitarian 3
507-206-2721
andrea.kieffer@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

CANNON FALLS ASSISTED LIVING
Cannon Falls
County/Group: Goodhue County

Inspection Info

Report Number: F8074261080
Inspection Type: Full
Date: 8/18/2026
Time: 2:22:07 PM

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding

Location: Ice at 49 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** potato; **Temperature Process:** Hot-Holding

Location: Hot Well at 160 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** peas; **Temperature Process:** Hot-Holding

Location: Hot Well at 154 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ham; **Temperature Process:** Hot-Holding

Location: Hot Well at 156 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding

Location: Display Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** turkey; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

CANNON FALLS ASSISTED LIVING
Cannon Falls
County/Group: Goodhue County

Inspection Info

Report Number: F8074261080
Inspection Type: Full
Date: 8/18/2026
Time: 2:22:07 PM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 50 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL26730016	Date: 8/17/2026
Facility Name: Cannon Falls Assisted Living	
Facility Address: 900 Main St. W., Cannon Falls, MN 55009	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

2. 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. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: No remote release hardware was installed within the facility with the capacity to unlock the controlled egress doors in the fourth-floor memory care wing of the facility. The locked egress doors in the memory care wing should have the ability to be unlocked by facility from an approved location.

3. Interior vertical shafts, including stairways, elevator hoistways, and service and utility shafts, that connect two of more stories of a building, shall be enclosed or protected. When openings are required to be protected, opening protectives shall be maintained self-closing. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4, 1103.4.1]

Comments: An unprotected vertical shaft was created by the presence of vertical openings in the trash rooms on each floor of the building. Unprotected openings were present from the basement of the parking garage to the fourth floor where a garbage shoot had been removed. It appeared that the kitchen hood may have been routed to vent through a portion of this opening, but significant unprotected gaps were left open. The surveyor was able to look through the opening on the basement level and see up to the top floor, including observing some refuse that was left in the shaft

penetrations. The openings in the ceilings and floors provided a shaft that would allow smoke and fire to penetrate between levels and spread quickly. The vertical penetrations should be properly sealed and protected via approved methods and should be maintained in a manner that will prevent the ready spread of smoke or fire between floors of the building.

4. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

Comments: Proper clearance below sprinkler heads was not maintained in several storage closets throughout the building where decorative items were stacked very close to the sprinkler heads. Facility staff removed these items obstructing the sprinkler heads during the survey. Sprinkler heads should be maintained free of obstruction and proper clearance should be maintained to ensure proper water flow during a sprinkler head activation.

5. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

Comments: The escutcheon rings around several sprinkler heads throughout the facility were missing. The escutcheon on the sprinkler head on the third floor of the East stairwell was installed incorrectly and was backwards. Escutcheons should be properly installed and maintained to ensure sprinkler heads activate and function as intended.

6. 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: Several fire-rated doors were propped open during the survey including unit doors on resident rooms, the therapy office room, and maintenance rooms. Fire doors should be maintained as properly self-closing or automatic closing so that they are able to securely shut and latch during an emergency to prevent the spread of smoke and fire.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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 licensee failed to provide adequate documentation of a safety risk assessment and mitigations for identified risks. Documentation of a safety risk assessment was provided to the surveyor but failed to outline any mitigation efforts for the identified risks. The safety risk assessment should be reviewed and updated to include mitigations to the identified hazards.