Electronically Delivered

April 30, 2026

Licensee
Spring Grove Assisted Living
130 5th Avenue Southeast
Spring Grove, MN  55974

RE:  Project Number(s) SL30478016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 15, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

**STATE CORRECTION ORDERS**

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

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

KKM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30478 | A. BUILDING: _____ B. WING _____ | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING GROVE ASSISTED LIVING | 130 5TH AVENUE SE SPRING GROVE, MN 55974 |

| (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 |
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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL30478016-0<br><br>On April 13, 2026, through April 15, 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 18 residents; 18 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 1<br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(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<br><br>allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 13, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. | 0 480 | | |

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| 0 480 | Continued From page 3<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case | 01060 | | |

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| 01060 | Continued From page 4<br><br>manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R3).<br><br>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).<br><br>The findings include:<br><br>R3 began receiving services on February 2, 2019, with diagnoses including fibromyalgia, congestive heart failure, kidney disease and chronic respiratory failure with hypoxia (low oxygen level).<br><br>R3's Service Plan dated May 3, 2026, included the services of medication management/administration, assistance with dressing, bathing, oxygen maintenance, and socialization.<br><br>On April 13, 2026, at 2:10 p.m., the surveyor | 01060 | | |

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| 01060 | Continued From page 5<br><br>observed assistant manager/unlicensed personnel (AM/ULP)-B administer one oral and one topical medication to R3.<br><br>R3's record included progress notes including:<br>- January 2, 2026, indicated emergency relocation notification that indicated R3 was transferred to [hospital name], following a doctor's appointment concerning shortness of breath and leg pain with suspicion for possible pulmonary embolism (blood clot in the lung). The entry indicated an unknown length of stay.<br>-January 5, 2026, indicated the hospital recommended a skilled nursing facility (SNF) stay for short term rehab. R3 was not discharged to return to the ALF facility<br><br>R3's SNF discharge summary/orders dated April 2, 2026, indicated R3 had received services at the SNF since January 7, 2026, with discharge back to the assisted living facility on April 2, 2026.<br><br>The licensee completed an emergency relocation entry as required; however, did not notify the ombudsman of R3's emergency relocation when R3 had not returned to the assisted living facility after four days, as required.<br><br>On April 13, 2026, at 12:40 p.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A stated she writes a progress note indicating an emergency relocation with any resident hospitalization; however, she was not aware of the requirement to notify the ombudsman if/when the resident did not return to the facility within four days.<br><br>The licensee's Contract Termination and Emergency Relocation policy dated October 15, 2022, indicated in the event of an emergency | 01060 | | |

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| 01060 | Continued From page 6<br><br>relocation, the facility must provide a written notice that contains at minimum:<br>The reason for the relocation;<br>- the name and contact information for the location to which the resident has been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care;<br>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;<br>- a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54.<br>The facility must provide contact information for the agency to which the residents may submit an appeal.<br>The notice required will be delivered as soon as practicable to:<br>a) the resident, legal representative, and designated representative;<br>b) for residents who receive home and community-based waiver services under the resident's case manager; and<br>c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) days. | 01060 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and | 01530 | | |

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| 01530 | Continued From page 7<br><br>de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; | 01530 | | |

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| 01530 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of two employees (ULP)-D) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>ULP-D had a hire date of October 28, 2025, and provided direct care services under the licensee's Assisted Living license.<br><br>ULP-D's employee record included an Educare training transcript (the licensee's online training program), printed April 14, 2026, indicating ULP-D completed 7.5 hours of dementia and lacked the required eight hours of dementia related training.<br><br>On April 14, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A stated she assigned dementia related training for the staff and had recently changed Educare training package groupings and missed assigning a training. She further stated this error only affected ULP-D (the most recent hire). In addition, ULP-D has worked more than 160 hours since being hired. | 01530 | | |

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| 01530 | Continued From page 9<br><br>The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the start date. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01530 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in the facility's medication refrigerator. This had the potential to affect the licensee's current residents.<br><br>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 | 01880 | | |

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| 01880 | Continued From page 10<br>or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>During the entrance conference on April 13, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A stated the licensee had a locked small medication refrigerator kept in the medication room for any resident medications needing refrigeration.<br><br>On April 13, 2026, at 2:30 p.m., the surveyor and assistant manager/unlicensed personnel (AM/ULP)-B reviewed the medication room and the medication refrigerator. AM/ULP-B stated the licensee checked the medication refrigerator temperature; however, she stated it was likely not daily and could not find the temperature log. The refrigerator contained a thermometer that sat inside the refrigerator and read 38 degrees Fahrenheit. The contents of the refrigerator included:<br>- R4 Florajen capsules with 28 capsules in a bubble pack and a full bottle of the medication<br>- R6 Zepbound injectable pens- four pens stored in the refrigerator<br><br>R6's Zepbound packaging included instructions to store the medication between 36-46 degrees Fahrenheit (F).<br><br>Florajen package instructions indicated capsules should be stored in refrigerator between 36-46 degrees F and could be stored at room temperature for up to two weeks.<br><br>The licensee failed to store temperature sensitive medications according to the manufacturer's | 01880 | | |

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| | 30478 | A. BUILDING: _____ B. WING _____ | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING GROVE ASSISTED LIVING | 130 5TH AVENUE SE SPRING GROVE, MN 55974 |

| (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 |
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| 01880 | Continued From page 11<br>recommendations.<br><br>On April 13, 2026, at 2:40 p.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A stated she was aware the medication refrigerator needed temperature monitoring, was not sure where the temperature log went, but would assign a new task to a shift to ensure this was done daily.<br><br>The licensee's Storage of Medications policy dated April 19, 2022, indicated when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications bore a proper label and included an open date for one of 18 residents (R4). | 01890 | | |

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| 01890 | Continued From page 12<br><br>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).<br><br>The findings include:<br><br>On April 13, 2026, at 2:30 p.m., the surveyor and assistant manager/unlicensed personnel (AM/ULP)-B reviewed the contents of medications stored in the medication cabinet in the nurse's office. The area housing R4's medications included:<br>- albuterol inhaler with 114 doses remaining and lacked a proper label to indicate name, dosing, route and frequency; and<br>- Systane eye drops labeled with only R4's name and lacked proper labeling to include dose and frequency. Additionally, the Systane eye drops lacked an open date.<br><br>Systane eye drop manufacturer's instructions dated September 12, 2024, indicated once opened, most Systane eye drops are safe to use for up to one month.<br><br>On April 13, 2026, at 2:40 p.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A stated all medications should have a proper label and time sensitive medications should include an open date. LALD/CNS/O-A further stated, sometimes families brought in medications when a resident is admitted and lacked the proper label and open | 01890 | | |

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| 01890 | Continued From page 13<br>date; but would monitor this moving forward.<br><br>The licensee's Storage of Medications dated April 19, 2022, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01890 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>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:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; | 01940 | | |

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| 01940 | Continued From page 14<br><br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of three residents (R1, R3) with treatments/delegated tasks.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on April 13, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor/owner (LALD/CNS/O)-A confirmed the licensee provided | 01940 | | |

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| 01940 | Continued From page 15<br><br>treatment and therapy services to residents as prescribed.<br><br>R1<br>R1 was admitted to the facility on May 22, 2025, with diagnoses including right femur fracture, type 2 diabetes, and cerebrovascular disease (brain deterioration).<br><br>R1's Service Plan dated May 23, 2025, included the service of daily blood sugar monitoring.<br><br>On April 14, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications and check R1's blood sugar. ULP-C then documented R1's blood sugar in R1's record. The surveyor and ULP-C observed R1's record lacked blood sugar parameters for which the ULP should contact a nurse. ULP-C stated she's seen blood sugar parameters written in other residents' records but was unable to see them with R1's information.<br><br>R1's Service Recap Summary dated April 2026, indicated blood sugar check daily. No further instructions (parameters noted).<br><br>R1's signed prescriber's orders dated April 2, 2026, indicated blood sugar check daily and as needed (PRN).<br><br>R1's RN assessment dated February 22, 2026, indicated monitor BS (blood sugar) daily. No further instructions were given.<br><br>R1's plan of care printed April 14, 2026, indicated "wearing gloves, and following agency procedure, check blood glucose (blood sugar), daily and record. Notify the nurse if out of range (85-200). (parameters were added to the plan of care | 01940 | | |

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| 01940 | Continued From page 16<br><br>following surveyor's discussion with LALD/CNS/O-A.)<br><br>On April 14, 2026, at 9:20 a.m., LALD/CNS/O-A stated she was aware of the need to add blood sugar parameters for residents receiving that service by the licensee; however, she had missed adding this to R1's information. She further stated ULP-C had shared with her earlier that this was missing and she corrected it before our discussion.<br><br>R3<br>R3 began receiving services on February 2, 2019, with diagnoses including fibromyalgia, congestive heart failure, kidney disease and chronic respiratory failure with hypoxia (low oxygen level).<br><br>R3's Service Plan dated April 3, 2026, included the service of "daily encounter" (daily compression wrap to R3's left upper arm).<br><br>On April 14, 2026, at 9:05 a.m., the surveyor observed ULP-C administer R3's oral medications and wrap R3's left bicep with a compression (ACE) wrap.<br><br>R3's signed prescriber's orders dated April 2, 2026, indicated wrap left upper extremity (LUE) bicep making sure not to cover elbow/shoulder. On in a.m. and off in p.m.<br><br>R3's Plan of Care effective April 3, 2026, indicated "wrap left arm with ACE wrap (stretchable, reusable wrap used to provide compression and support for sprains, strains, and swelling reduction) above elbow to help wrap her excess skin as this helps with pain". No further instruction noted. | 01940 | | |

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| 01940 | Continued From page 17<br><br>R3's RN assessment dated April 3, 2026, in section labeled dressing, indicated "needs help with ACE bandage, ACE bandage to left elbow to help wrap her excess skin." No further instruction noted.<br><br>R3's Service Recap Summary dated April 2026, indicated "RCA (resident care assistant) care daily", assigned for a.m. and p.m.<br><br>The licensee failed to include written instructions for R3's left upper arm compression wrap and what staff should monitor for (redness, open skin areas) and report to nursing.<br><br>On April 14, 2026, at 9:20 a.m., LALD/CNS/O-A stated she understood she needed to write additional instructions for resident treatments and indicate to ULP what concerns needed to be reported to nursing; and further stated R3's ACE compression was a new treatment, and she missed adding the additional instructions to monitor for skin concerns.<br><br>The licensee's Delegation of Nursing Tasks dated August 21, 2021, indicated when needed, the RN will provide written instructions for performing the procedure to the ULP. Nursing tasks will be appropriately delegated to unlicensed personnel, using the licensed nurse's professional judgment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01940 | | |

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

# Food & Beverage Inspection Report



## Establishment Info

Spring Grove Assisted Living
130 5TH AVENUE SE
Spring Grove, MN 55974
Houston County
Parcel:

Phone: 507-498-4000
nkimmerle@gmail.com

## License Info

License: HFID 30478
Nikki Kimmerli
Risk:
License:
Expires on:
CFPM: Barb Peters
CFPM #: FM61749; Exp: 06/29/2028

## Inspection Info

Report Number: F1045261048
Inspection Type: Full - Single
Date: 4/13/2026 Time: 2:11:25 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

**New Order: 5-200C Plumbing: Maintenance, fixture location**
5-205.13 *Priority Level: Priority 2 CFP#: 51*
*MN Rule 4626.1120* Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.
COMMENT:
Replace ice machine water filter. Last replaced was over 1 year ago
*Comply By: 4/13/2026 Originally Issued On: 4/13/2026*

# Food & Beverage General Comment

Reviewed food cooking and holding temperatures. Ill employee policy and handwashing procedures. Thermometers are regularly calibrated using ice method and gloves worn during food prep activities.

**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 F1045261048 from 4/13/2026**

Nikki Kimmerle
Director

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us