Electronically Delivered

December 24, 2025

Licensee
Cannon Country
308 Larkspur Lane
Cannon Falls, MN 55009

RE: Project Number(s) SL37873016

Dear Licensee:

On November 11, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 15, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 15, 2025, found not corrected at the time of the November 11, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on November 11, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	R 11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37873016-2 On November 10, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 27, 2025. As a result of the follow-up survey, the following order was reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 1 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 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:	{0 480}	Not reviewed during this survey.	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 2 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.	
{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 and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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	{0 775}		

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{0 775}	Continued From page 3 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 10, 2025, at 2:00 p.m., surveyor requested to tour R6's bedroom, identified as library on facility floor plan. Surveyor was escorted by LALD-B, resident no longer resides in that area of the house. Resident moved into a shared room where the exit goes through another resident room. Means of egress from dwelling units or sleeping areas shall not lead through other sleeping areas, toilet rooms or bathrooms. On November 10, 2025, at 2:30 p.m.; LALD-B showed new construction plans for resident rooms 1, 2 and 5 to be remodeled to meet code requirements. Project plans are being reviewed by MDH; carbon monoxide alarm was not re-checked during this inspection. TIME PERIOD FOR CORRECTION: Two (2) days	{0 775}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	{0 810}		

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{0 810}	Continued From page 4 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{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;	{01650}		

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{01650}	Continued From page 5 (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:	{01650}	Not reviewed during this survey.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 16, 2025

Licensee
Cannon Country
308 Larkspur Lane
Cannon Falls, MN 55009

RE: License Number 421680
Health Facility Identification Number (HFID) 37873
Project Number(s) SL37873016

Dear Licensee:

On August 27, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed January 15, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective August 27th, 2025.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 15, 2025, found not corrected at the time of the follow-up survey and/or subject to a penalty assessment are as follows:

0480-Minimum Requirements; Required Food Services-144g.41 Subdivision 1 Subd. 1a (a-B) - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $500.00
0830-Local Laws Apply-144g.45 Subd. 3 - $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on August 26, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on August 26, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0775-Fire Protection And Physical Environment-144g.45 Subd. 2. - $500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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).

IMPOSITION OF FINES:

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.

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.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37873016-1 On August 25, 2025, through August 27, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 15, 2025. At the time of the survey, there were nine (9) residents receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued.	{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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide documentation with actions taken to comply with correction orders from a survey completed on January 13, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 340		

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0 340	Continued From page 2 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: During a survey conducted on August 26, 2025, the licensee was cited using the 0830 tag identification number for failure to submit a plan review application for the addition of a resident sleeping room On August 26, 2025, between 3:00 p.m. and 4:00 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed the library was occupied by a resident and used as a sleeping room. The surveyor requested documentation that the licensee had submitted a plan review application to Minnesota Department of Health Engineering Services for the change in use of the library into a resident sleeping room. During the tour interview, O-A stated the plan review application had not been submitted and verified the library was occupied as a resident sleeping room. The surveyor confirmed the deficient condition remained. Previous survey 0830 tag identification number findings: On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and owner (O)-A. During the tour, the surveyor observed the posted floor plans labeled a room as a library. This "library" was occupied by a resident and used as their sleeping room. LALD-B stated during the facility tour interview that the "library" was made into a	0 340		

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0 340	Continued From page 3 resident room approximately 9 months to a year ago. LALD-B verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the addition of this resident sleeping room. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not	{0 480}		

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	37873	A. BUILDING: _____ B. WING _____	R 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE CANNON FALLS, MN 55009

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{0 480}	Continued From page 4 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 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: Not reviewed during this survey.	{0 480}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	{0 660}		

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{0 660}	Continued From page 5 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of two unlicensed personnel (ULP-I and ULP J). This had the potential to affect all residents, staff and visitors. 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: ULP-I and ULP-J were hired on May 23, 2025, and July 29, 2024, respectively.	{0 660}		

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{0 660}	Continued From page 6 ULP-I's record included a self-titled document with an encounter date of May 22, 2025, which indicated ULP-I had their TB TST results read by a nurse but failed to indicate if the reading was from a first or second step. The results were negative for TB. ULP-J's Tuberculosis (TB) Screening indicated ULP-J had their first of two step TST results completed on July 29, 2024. ULP-J's record lacked evidence ULP-J completed the second step of the TST. On August 25, 2025, at 1:00 p.m., licensed assisted living director (LALD)-B stated licensee was unable to locate evidence both ULP-I and ULP-J had completed both steps for their TST. LALD-B stated both ULPs would be required to complete the two step TST process again to ensure all requirements were met for the licensee's TB TST policy. LALD-B stated licensee had recently started to use an electronic tracking system for all staff but had not performed audits yet as items were still being loaded into the licensee's new system. The licensee's Conditional License Plan of Correction dated August 21, 2025, completed by licensee's required consultant indicated consultant had provided education on requirements for a TB screening and testing to licensee and audits were to occur to ensure compliance. The licensee's 8.16 Tuberculosis Screening policy dated July 25, 2025, indicated all staff would have a completed two-step Mantoux conducted prior to providing services and evidence of the Mantoux would be documented	{0 660}		

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{0 660}	Continued From page 7 and maintained in the employee's records. No further information was provided.	{0 660}		
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 and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: - On August 25, 2025, at 11:50 a.m., surveyor requested to tour R4's bedroom, identified on licensee's Current Resident Roster as 5B. Surveyor was escorted by unlicensed personnel (ULP) to a room identified at 5A and 5B. Upon entering the identified room, cloth floor standing dividers were noted. The dividers prevented a person entering the room from seeing the area	0 775		

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0 775	Continued From page 8 behind the curtain. ULP stated area was R1's room where R1 slept and spent their time. The dividers led to another door within R1's living area labeled 5B. R4 was seated in their recliner inside of the room labeled 5B and stated the room was their bedroom and invited surveyor to enter their room for a tour. R4's emergency exit path from their bedroom required R4 to pass through R1's living area to access the door to the common hallway. Means of egress from dwelling units or sleeping areas shall not lead through other sleeping areas, toilet rooms or bathrooms. - On August 26, 2025, between 3:00 p.m. and 4:00 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed carbon monoxide alarms were not installed outside and within ten feet of occupied resident sleeping rooms 3, 4, 5, and the library. During the facility tour interview, O-A verified carbon monoxide alarms were not installed in these locations. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}		

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{0 800}	Continued From page 9 This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and maintain a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On August 26, 2025, owner (O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to identify the location and number of resident sleeping rooms and an emergency exit. On August 26, 2025, between 3:00 p.m. and 4:00 p.m., the surveyor toured the facility with O-A. During the tour, the surveyor observed the following: 1. The posted FSEP floor plans labeled a resident sleeping room as a library. This occupied room was verbally identified as a resident sleeping room by O-A during the tour. Resident sleeping	{0 810}		

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{0 810}	Continued From page 11 rooms must be accurately identified to provide efficient communication for exiting in the event of a fire or similar emergency. 2. An illuminated exit sign was installed for a side door (adjacent to the door for the garage) leading out to the front of the building. This exit was not labeled on the FSEP floor plans. Exit labels are required to be included on the FSEP floor plans in order to direct occupants to the exits in the event of an emergency. During the facility tour interview on August 26, 2025, O-A verified the FSEP floor plan had not been maintained. The FSEP floor plans shall be readily understandable by the building occupants in the event of an emergency. 3. Record review of the available documentation indicated the licensee FSEP was not developed with site specific procedures for the assisted living facility and the building occupants. The FSEP was a template from a third-party provider. - The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these actions in the plan. - The FSEP failed to identify fire protection procedures necessary for residents evident by a lack of these procedures in the plan . - The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview, on August 26, 2025, between 3:00 and 4:00 p.m., O-A-B verified the FSEP was a template from a third party provider. TRAINING Record review indicated the licensee failed to	{0 810}		

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{0 810}	Continued From page 12 provide training to employees on the FSEP at least twice per year after hire evident by the lack of training documentation. Employee FSEP training records were requested by the surveyor on August 26, 2025, from O-A. Employee FSEP training records were not provided. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. Resident fire safety and evacuation training records were requested by the surveyor on August 26, 2025, from O-A. Resident fire safety and evacuation training records were not provided. During an interview on August 26, 2025, between 3:00 p.m. and 4:00 p.m.., O-A stated these training records were not kept onsite. No further information was provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill logs lacking the required frequency. Records for evacuation drills conducted since the previous survey in January 2025 were requested by the surveyor on August 26, 2025, from O-A. One fire drill record dated August 1, 2025, was provided. During an interview on August 26, 2025, between 3:00 p.m. and 4:00 p.m., O-A stated all of the drill records were not kept onsite. No further information was provided.	{0 810}		
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all	{0 830}		

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{0 830}	Continued From page 13 applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for the addition of a resident sleeping room. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On August 26, 2025, between 3:00 p.m. and 4:00 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed the library was occupied by a resident and used as a sleeping room. The surveyor requested documentation that the licensee had submitted a plan review application to Minnesota Department of Health Engineering Services for the change in use of the library into a resident sleeping room. During the tour interview, O-A stated the plan	{0 830}		

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{0 830}	Continued From page 14 review application had not been submitted and verified the library was occupied as a resident sleeping room.	{0 830}		
{01650} SS=C	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 15 licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, 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 July 15, 2024. R1's Service Plan - Modification was signed August 8, 2025, and lacked the schedule and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services, and a contingency plan with all required content. R2 R2 was admitted on February 19, 2024. R2's Service Plan - Modification was signed August 8, 2025, and lacked the schedule and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services, and a contingency plan with all required content. R4 R4 was admitted on March 27, 2024.	{01650}		

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{01650}	Continued From page 16 R4's Service Plan - Modification was signed August 13, 2025, and lacked the schedule and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services, and a contingency plan with all required content. On August 26, 2025, at 10:30 a.m., owner (O)-A stated licensee had recently transitioned to a new electronic health record (EHR) which generated service plans based on the assessment of each resident. O-A stated licensee had selected the incorrect service plan form for every resident and each service plan would lack the identified items above. O-A then provided new service plans for each resident which included the missing requirements. O-A stated licensee had located the correct form in the EHR and would generate the accurate service plan going forward. The licensee's Conditional License Plan of Correction dated August 21, 2025, completed by licensee's required consultant indicated licensee would utilize the newly implemented EHR to generate service plans and clinical nurse supervisor was educate on service plan required content. The licensee's 6.08 Service Plan policy dated July 25, 2025, indicated each resident service plan would include the identified lacking required content and be included in the resident record. No further information was provided.	{01650}		

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

July 15, 2025

Licensee
Cannon Country
308 Larkspur Lane
Cannon Falls, MN 55009

RE: Project Number(s) SL37873016

Dear Licensee:

Please note: This letter amends the previous letter dated March 14, 2025. Specifically, following the results of the informal conference and Stipulated Agreement, the original fines were rescinded. As a result of the rescinded penalties, language related to the fines imposed were also removed from this notice. Further, your right to request a reconsideration has expired with the previous notice dated March 14, 2025.

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Cannon Country. Please contact Jodi Johnson at 507-344-2730 on or before **Wednesday, March 19, 2025**, to schedule the conference call.

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

HHH

Electronically Delivered

March 14, 2025

Licensee
Cannon Country
308 Larkspur Lane
Cannon Falls, MN 55009

RE: Project Number(s) SL37873016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, 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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Cannon Country. Please contact Jodi Johnson at 507-344-2730 on or before **Wednesday, March 19, 2025**, to schedule the conference call.

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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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE 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 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: SL37873016-0 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were seven residents; seven receiving services under the Assisted Living Facility license. 0470: An immediate order was issued on January 14, 2025, at a level 3/Widespread (I) The licensee took action on January 14, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs. This resulted in an immediate correction	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 2 order on January 14, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license dated August 1, 2024, through July 31, 2025, with a health facility identification (HFID)-37873. The licensee had a capacity of ten residents with a current total census of seven residents. CNS-C stated the licensee's facility had a "sister" facility (with a separate license HFID-40353) and was located across the road/cul-de-sac. The facilities were designated as house one (HFID-37873) and house two (HFID- 40353). On January 13, 2025, at 9:15 a.m. during the entrance conference, clinical nurse supervisor (CNS)-C stated the licensee had one awake staff available at the facility which included one unlicensed personnel (ULP) during the night shift 11:00 p.m. to 7:00 a.m. The staff schedule dated January 12, 2025, through January 18, 2025, included the schedule for both houses for each shift. The night shift (11:00 p.m.-7:00 a.m.) on January 13, 2025, indicated owner/ULP (O/ULP)-F was scheduled for house one and O/ULP-A was scheduled for house two.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 3 On January 14, 2025, at approximately 6:30 a.m., the surveyor entered the facility and observed R3 sitting at the dining room table in the dark. The surveyor walked around the facility and could not locate any staff. The surveyor sat in the dining room with R3. At 6:41 a.m., the surveyor could see O/ULP-F walking out of the sister facility (HFID 40353) and walk over to house one (HFID 37873). O/ULP-F stated he wasn't expecting the surveyor to arrive so early. The surveyor inquired about where O/ULP-F was and he stated he was outside clearing snow. The surveyor explained that no staff were seen outside of either house since the surveyor had arrived. O/ULP-F then stated he ran over to house two to get his jacket. O/ULP-F was unsure how long he was gone. O/ULP-F then went outside and cleared snow from the driveway. On January 14, 2025, at 7:00 a.m., CNS-C arrived at the facility. The surveyor inquired about staff leaving the facility unattended and CNS-C stated the facility was required to have staff present at all times. CNS-C confirmed O/ULP-F was scheduled to work the entire night shift at house one and O/ULP-A was scheduled to work the entire night shift at house two. On January 14, 2025, at 7:09 a.m., O/ULP-A arrived at the house one and stated he was at house two all night and did not know why O/ULP-F would have left house one for any reason. O/ULP-A stated he understood that they had to have two staff working (one staff for house one, and one staff for house two); however; O/ULP-A stated he did not understand that the staff couldn't leave one of the houses to walk over to the other house for a short period of time if they needed something.	0 470		

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0 470	Continued From page 4 The licensee's undated, Facility Staffing Plan for house one (HFID 37873) included the days of the week Monday through Sunday. Each late-night shift (11:00 p.m.-7:00 a.m.) indicated one ULP for each night in house one. The licensee failed to ensure one or more awake staff were available in the building 24 hours per day. Additionally, the licensee's staffing plan lacked a review date and/or indication the staffing plan was reviewed twice each year by the registered nurse (RN), as required. The licensee's Staffing policy dated August 1, 2021, indicted The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet the residents' needs at all times, including reasonably foreseeable needs. No further information provided. TIME PERIOD FOR CORRECTION: Immediate On January 14, 2025, the licensee implemented measures to mitigate risk to resident safety; however, the scope and severity remains at I.	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 5 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 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	0 480		

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0 480	Continued From page 6 (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 January 13, 2025, 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 to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of	0 500		

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0 500	Continued From page 7 maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks.	0 500		

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0 500	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 13, 2025, at 9:10 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-C stated they were aware of the current minimum assisted living regulations and requirements of 144G.41. During the survey from January 13, 2025, through January 15, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents. The licensee failed to implement policies and procedures to address the following: Requirements in section 626.557, reporting of maltreatment of vulnerable adults -Refer to licensing order 0630, at MN Statute	0 500		

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0 500	Continued From page 9 144G.42 Subd. 6. (b). The licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). - Refer to licensing order 0660 at MN Statute 144G.42. Subd. 9. The licensee failed to ensure TB history and symptom screening, and two-step tuberculin skin test (TST) were completed according to protocol for three of three employees (unlicensed personnel (ULP)-D, ULP-E and owner (O)/ULP-F). -Refer to licensing order 1370 and 1380, at MN Statute 144G.61 Subd. 2. The licensee failed to ensure training ad competency was completed for three of three employees (ULP-D, ULP-E and O/ULP-F). -Refer to licensing order 1440, at MN Statute 144G.62 Subd. 4. The licensee failed to perform direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual first performed the delegated tasks for two of two unlicensed personnel (ULP-D and ULP-E). -Refer to licensing order 1470, at MN Statute 144G.63 Subd. 2. The licensee failed to ensure orientation was completed including all required content, before working with residents, for two of three unlicensed personnel (ULP-D and ULP-E). -Refer to licensing order 1500, at MN Statute 144G.63 Subd. 5. The licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (O/ULP-F). -Refer to licensing order 1530, at MN Statute	0 500		

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	37873	A. BUILDING: _____ B. WING _____	01/15/2025

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0 500	Continued From page 10 144G.64 (a) (1-2). The licensee failed to ensure supervisors and direct-care staff completed the required amount of dementia care training within the required timeframe for three of three employees (ULP-D, ULP-E, and O/ULP-F). -Refer to licensing order 1610, at MN Statute 144G.70 Subd. 2. The licensee failed to ensure a registered nurse conduction an initial assessment prior to the initiation of services for two of two residents (R1 and R2). -Refer to licensing order 1620, at MN Statute 144G.70 Subd. 2. The licensee failed to complete a 14 day assessment and subsequent 90 day comprehensive nursing assessments utilizing a uniform assessment tool; for two of two residents (R1 and R2). -Refer to licensing order 1700, at MN Statue 144G.71 Subd. 2. The licensee failed to ensure the registered nurse conducted a face-to-face medication management assessment to include all required content for two of two residents (R1 and R2). - Refer to licensing order 1730 at MN Statute 144G.71 Subd. 5. The licensee failed to ensure individual medication management plans contain all the required content for two of two residents (R1 and R2). - Refer to licensing order 1750 at MN Statute 144G.71 Subd. 7. The licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R2). - Refer to licensing order 1760 at MN Statute 144G.71 Subd. 8. The licensee failed to ensure	0 500		

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0 500	Continued From page 11 documentation included the effectiveness for as needed medications for one of two residents R2). -Refer to licensing order 1820, at MN Statute 144G.71 Subd. 13. The licensee failed to ensure there was a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for two of two residents (R1 and R2); -Refer to licensing order 1940, at MN Statute 144G.72 Subd. 3. The licensee failed to complete an individualized medication management plan for two of two residents (R1 and R2); and -Refer to licensing order 1970, at MN Statute 144G.72 Subd. 6. The licensee failed to ensure there was an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies, for two of two residents (R1 and R2). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 630 SS=E	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	0 630		

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0 630	Continued From page 12 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include bathing, nail and foot care, skin care, standby assistance, meal assistance, homemaker services, monthly vital signs, blood glucose monitoring and medication administration. On January 13, 2025, at 3:15 p.m., the surveyor observed unlicensed personnel (ULP)-E	0 630		

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0 630	Continued From page 13 administer medications to R1. R1's IAPP (included within R1's comprehensive assessments) dated January 11, 2025, indicated: "Do Vulnerabilities exist in each area", with columns labeled "Yes" and "No". Mark "yes" if there is a problem in the area and mark "No" if there is no problem. Additionally, the IAPP included a column to read "Complete a specific plan for all areas marked "Yes". In the column marked "Yes" (there is a problem) and the column labeled "Complete a specific plan" (interventions) indicated the following: -visual difficulties-lacked interventions -able to ambulate with/without device-intervention: walks with white cane In the column Marked "No" (there is no problem) indicated the following: -orientation to person, place and time -environment safe/clean -hearing difficulties -speech/language barriers -understands/follows instructions -risk for elopement -chronic conditions(s)/pain/illness/disability -ability to use telephone -ability to manage finances -social support system -presence of risk factors in environment or with other residents -susceptible to abuse by others in home or community environment -ability to report abuse/neglect concerns The following listed vulnerabilities in R1's IAPP were not assessed and left blank. -ability to self-administer medications -possesses functional limitations	0 630		

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0 630	Continued From page 14 -resident at risk for abusing other vulnerable individuals The licensee failed to accurately identify R1's vulnerabilities and include interventions to minimize the risk for abuse/self-neglect/self-harm for a vulnerable adult. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include dressing, bathing, nail and foot care, skin care, toileting, supervision with ambulation, meal assistance, monthly vital signs, blood glucose monitoring and medication administration. On January 14, 2025, at 8:50 a.m., the surveyor observed ULP-D administer medications to R2. R2's IAPP (included within R2's comprehensive assessments) dated January 11, 2025, indicated: "Do Vulnerabilities exist in each area", with columns labeled "Yes" and "No". Mark "yes" if there is a problem in the area and mark "No" if there is no problem. Additionally, the IAPP included a column to read "Complete a specific plan for all areas marked "Yes". In the column marked "Yes" (there is a problem) and the column labeled "Complete a specific plan" (interventions) indicated R2 did not have any vulnerabilities as none of the areas were marked "Yes". In the column Marked "No" (there is no problem) indicated the following:	0 630		

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0 630	Continued From page 15 -Oriented to person, place and time -environment safe/clean -visual difficulties -hearing difficulties -speech/language barriers -understands/follows instructions -able to ambulate safely with/without devices -risk for elopement -ability to use telephone -ability to manage finances -ability to self-administer medications -presence of risk factors in environment or with other residents -susceptible to abuse by other sin home or community environment -ability to report abuse/neglect concerns -resident at risk for abusing other vulnerable individuals The following listed vulnerabilities in R2's IAPP were not assessed and left blank. -chronic condition(s)/pain/illness/disability -social support system -possesses functional limitations The licensee failed to accurately identify R2's vulnerabilities and include interventions to minimize the risk for abuse/self-neglect/self-harm for a vulnerable adult. On January 15, 2025, at 8:08 a.m., clinical nurse supervisor (CNS)-C stated she was new to the facility and had not had a chance to review and update resident's IAPPs for accuracy. CNS-C and licensed assisted living director (LALD)-B stated R1 and R2 were vulnerable adults and had vulnerabilities that were not assessed accurately within their IAPP. The licensee's Vulnerable Adult policy dated	0 630		

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0 630	Continued From page 16 August 1, 2021, indicated residents would be assessed to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. The IAPP would include: -The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. -The plan shall contain the resident's risk of abusing other vulnerable adults. -The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. -The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. -Documentation will include results of the implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	0 660		

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0 660	Continued From page 17 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a completed facility TB risk assessment, documentation of a completed health history and symptom screening and failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for three of three employees (unlicensed personnel (ULP)-D, ULP-E and owner (O)/ULP-F). This practice resulted in a level two violation (a violation that did no 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: On January 13, 2025, at 9:34 a.m., the surveyor requested the licensee's TB risk assessment. On January 14, 2025, at 8:08 a.m., licensed assisted living director (LALD)-B emailed the surveyor the Facility TB risk assessment; however, it was a blank copy of the TB risk	0 660		

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0 660	Continued From page 18 assessment. ULP-D ULP-D was hired on November 29, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of the following: -TB history and symptom screening -Two-step TST or other evidence of TB screening such as a blood test. ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of the following: -TB history and symptom screening -Two-step TST or other evidence of TB screening such as a blood test. O/ULP-F O/ULP-F was hired on August 28, 2020, to provide direct care and services to the facility's residents. O/ULP-F's employee record lacked evidence of the following: -TB history and symptom screening -second step TST. On January 15, 2025, at 8:07 a.m., licensed assisted living director (LALD)-B stated ULP-D, ULP-E, and O/ULP-F's employee records lacked the required content as listed above. LALD-B further stated the TB risk assessment was not complete.	0 660		

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0 660	Continued From page 19 The licensee's Tuberculosis Screening/Prevention policy dated January 10, 2025, indicated the following: -The Director would conduct the formal TB Risk Assessment and update it annually. -Employees would receive baseline TB screening which included an assessment for TB history and current TB symptoms and a baseline TST or BAMT. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 20 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan lacked evidence of the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - arrangements/contracts to re-establish utility services; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures based on the EP, risk assessment and communication plan;	0 680		

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0 680	Continued From page 21 - Policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - Policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information	0 680		

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0 680	Continued From page 22 for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles; and - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On January 15, 2025, at 9:09 a.m., clinical nurse supervisor (CNS)-C stated licensee's current EP plan did not include the above required content.	0 680		

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0 680	Continued From page 23 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 690		

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	37873	A. BUILDING: _____ B. WING _____	01/15/2025

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0 690	Continued From page 24 The findings include: R1 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include bathing, nail and foot care, skin care, standby assistance, meal assistance, homemaker services, monthly vital signs, blood glucose monitoring and medication administration. R1's Medication and Treatment Record dated January 2025, included staff initials but lacked staff names/signatures and credentials/title. R1's Services Charting Sheet dated January 2025, included staff initials but lacked staff names/signatures and credentials/title. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include dressing, bathing, nail and foot care, skin care, toileting, supervision with ambulation, meal assistance, monthly vital signs, blood glucose monitoring and medication administration. R2's Medication and Treatment Record dated January 2025, included staff initials but lacked staff names/signatures and credentials/title. R2's Services Charting Sheet dated January	0 690		

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0 690	Continued From page 25 2025, included staff initials but lacked staff names/signatures and credentials/title. On January 15, 2025, at 8:13 a.m., licensed assisted living director (LALD)-B stated R1 and R2's documents listed above lacked staff names/signatures and credentials/titles. LALD-B further stated the same template for the Medication and Treatment Record and Services Charting Sheet was used for all residents. The licensee's Clinical Records policy dated August 1, 2021, indicated all entries into the clinical record will be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 26 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with smoke alarm requirements and Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and owner (O)-A. During the tour, the surveyor observed the following: SMOKE ALARMS 1. A smoke alarm was not installed in the bedroom for resident room verbally identified as room zero by LALD-B. 2. A smoke alarm was not installed outside resident room zero in the immediate vicinity of	0 780		

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0 780	Continued From page 27 this sleeping area. LALD-B verified these required smoke alarms were not installed. MEANS OF EGRESS 3. The posted floor plans labeled the door leading to the back patio as an exit. An exit sign was posted at this patio door. The patio was covered with snow and an exterior exit path from the patio to the public right of way was not maintained free of snow. 4. At the back of the kitchen, an illuminated exit sign was installed for a side door. An exterior path from this exit door to the public right of way was not maintained free of snow. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow. LALD-B stated it had snowed over the weekend and verified the above listed observations. FIRE ALARM AND SPRINKLER SYSTEM MAINTENANCE 5. Annual inspection tags and/or stickers were not available for the fire alarm and sprinkler systems. During the facility tour interview, the surveyor requested inspection reports for the fire alarm and sprinkler systems completed in the last year from LALD-B and O-A. An inspection report from the city dated 2022 was provided. LALD-B and O-A stated during the facility tour interview they were unsure if inspections had been completed since 2022 and would email the reports if located by 8:00 a.m. on January 14, 2025. No further information was provided to the surveyor. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790	Continued From page 28	0 790		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a portable fire extinguisher as required by statute. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and owner (O)-A. During the tour, the surveyor observed monthly inspections had not been recorded on the back of the tag attached to the portable fire extinguisher installed in the mechanical room. Fire extinguisher	0 790		

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0 790	Continued From page 29 inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, LALD-B verified monthly inspections had not been completed on this fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	0 800		

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0 800	Continued From page 30 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and owner (O)-A. During the tour, the surveyor observed the following: 1. One side of the bifold closet was off the track in resident occupied suite 2. 2. Part of the floor transition was broken and another section missing between the dining room and foyer. During the facility tour interview, LALD-B and O-A verified the above listed observations and stated the licensee already had these items scheduled for repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 31 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and maintain a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 32 On January 13, 2025, licensed assisted living director (LALD)-B and owner (O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to identify the location and number of resident sleeping rooms and an emergency exit. On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with LALD-B and O-A. During the tour, the surveyor observed the following: 1. The posted FSEP floor plans labeled a resident sleeping room as a library. This occupied resident room was verbally identified as room zero by LALD-B during the tour. 2. O-A verbally identified resident room 5 during the tour. The surveyor observed room identifiers were not posted on or at the resident room doors for rooms zero and 5. Resident sleeping room identifiers are required to be posted and correspond with the FSEP floor plan labels. Resident sleeping rooms must be accurately identified to provide efficient communication for exiting in the event of a fire or similar emergency. 3. An illuminated exit sign was installed for a side door (adjacent to the door for the garage) leading out to the front of the building. This exit was not labeled on the FSEP floor plans. Exit labels are required to be included on the FSEP floor plans in order to direct occupants to the exits in the event of an emergency. The FSEP floor plans shall be readily understandable by the building occupants in the event of an emergency. During the facility tour	0 810		

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0 810	Continued From page 33 interview, on January 13, 2025, LALD-B and O-A verified the above listed observations. 4. Record review indicated the licensee FSEP was not developed and maintained for the facility location. The FSEP fire safety policy dated August 1, 2021, was a template from a third-party provider. 5. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym. 6. The FSEP failed to identify fire protection procedures necessary for residents. The procedures were limited to directing residents to stoop or crawl to avoid smoke. 7. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. O-A emailed resident emergency preparedness priority codes to the surveyor on January 14, 2025, at 8:56 a.m. This information was not included with the FSEP provided to the surveyor on January 13, 2025. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview, on January 13, 2025, at 3:45 p.m., LALD-B verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year after hire evident by the lack of training documentation. Training records were	0 810		

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0 810	Continued From page 34 requested by the surveyor but not provided. During an interview on January 13, 2025, at 3:45 p.m., LALD-B stated employee were trained during evacuation fire drills and verified the FSEP training requirements were not met. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. Training records were requested by the surveyor but not provided. During an interview on January 13, 2025, at 3:45 p.m., LALD-B stated some residents participated during the employee evacuation fire drills and verified the training requirements were not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill logs lacking the required frequency. Four fire drills were recorded in 2024, completed in June, August, October, and December. The time or shift of these drills had not been recorded. No fire drill records were provided prior to June 2024. During an interview on January 13, 2025, at 3:45 p.m., LALD-B verified the evacuation drill frequency was not met and the required drill documentation not recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws,	0 830		

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0 830	Continued From page 35 regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for the addition of a resident sleeping room. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, at 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and owner (O)-A. During the tour, the surveyor observed the posted floor plans labeled a room as a library. This "library" was occupied by a resident and used as their sleeping room. LALD-B stated during the facility tour interview that the "library" was made into a resident room approximately 9 months to a year ago. LALD-B verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the addition of	0 830		

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0 830	Continued From page 36 this resident sleeping room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the	0 900		

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0 900	Continued From page 37 existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on July 15, 2024, with diagnoses that included diabetes. R1's Medication Administration Record (MAR) dated July 2024, indicated staff administered medications starting on July 15, 2024. R1's record contained an Assisted Living Contract and Lease Agreement dated as signed by R1's legal representative on July 18, 2024, three days after the licensee provided services to R1. On January 15, 2025, at 8:19 a.m., licensed assisted living director (LALD)-B stated R1's contract was not signed prior to providing services. No further information was provided.	0 900		

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	37873	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE CANNON FALLS, MN 55009

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0 900	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 950		

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0 950	Continued From page 39 licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 July 15, 2024, with diagnoses that included diabetes. R1's Assisted Living Contract dated July 15, 2024, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not	0 950		

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0 950	Continued From page 40 take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's Assisted Living Contract dated February 19, 2024, included an area to designate or decline a designated representative; however, it was left blank. The agreement lacked a separate page for designated representative to include the required verbiage. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On January 15, 2025, at 8:20 a.m., licensed assisted living director (LALD)-B stated R1 and R2's record did not have the correct verbiage for designated representative. LALD-B further stated the same contract was used for all residents at the facility.	0 950		

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0 950	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract included a clause that indicated the resident would waive	0 970		

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0 970	Continued From page 42 the licensee's liability for health, safety, or personal property of a resident. -the agreement indicated: "Indemnification: [facility name] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [facility name] harmless from any claims or damages unless caused solely by negligence of [facility name]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident". - "Liability: the resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where the contract has been executed by a party designated below. Or where a separate responsible party agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced. On January 15, 2025, at 8:22 a.m., licensed assisted living director (LALD)-B stated the licensee's contract included the above content, and further stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 43 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 44 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for three of three employees (unlicensed personnel (ULP)-D, ULP-E, and owner (O)/ULP-F) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-D ULP-D was hired on November 29, 2024, to provide direct care and services to the facility's residents. On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record lacked evidence of training for the following topics: -maintenance of a clean and safe environment; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a	01370		

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01370	Continued From page 45 licensed health professional; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; ULP-D's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's residents. On January 13, 2025, at 3:15 p.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -maintenance of a clean and safe environment; -training on the prevention of falls; -standby assistance techniques and how to perform them; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy;	01370		

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01370	Continued From page 46 -understanding appropriate boundaries between staff and residents and the resident's family; ULP-E's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them O/ULP-F O/ULP-F was hired on August 28, 2020, to provide direct care and services to the facility's residents. O/ULP-F's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -reports of change in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family. -awareness of commonly used health technology equipment and assistive devices. On January 15, 2025, at 9:04 a.m., licensed assisted living director (LALD)-B stated ULP-D,	01370		

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01370	Continued From page 47 ULP-E and O/ULP-F lacked documentation of the training and competency evaluations as listed above. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluation for all ULPs would include: - documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the home care provider -maintenance of clean and safe environment -appropriate and safe techniques in person hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -training on the prevention of falls for providers working with the elderly or individuals at risk of falls -standby assistance techniques and how to perform them -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -understanding appropriate boundaries between staff and residents and the resident's family -awareness of commonly used health technology equipment and assistive devices	01370		

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01370	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for three of three employees (unlicensed personnel (ULP)-D, ULP-E, and owner (O)/ULP-F) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01380		

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01380	Continued From page 49 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: ULP-D ULP-D was hired on November 29, 2024, to provide direct care and services to the facility's residents. On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; ULP-D's employee record lacked evidence of competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's	01380		

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01380	Continued From page 50 residents. On January 13, 2025, at 3:15 p.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; -recognizing physical, emotional, cognitive, and developmental needs of the resident; ULP-E's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. O/ULP-F O/ULP-F was hired on August 28, 2020, to provide direct care and services to the facility's residents. O/ULP-F's employee record lacked evidence of training for the following topics: -recognizing physical, emotional, cognitive, and developmental needs of the resident On January 15, 2025, at 9:04 a.m., licensed assisted living director (LALD)-B stated ULP-D, ULP-E and O/ULP-F lacked documentation of the training and competency evaluations as listed above. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluation for all ULPs would include: -observation, reporting, and documenting of	01380		

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01380	Continued From page 51 resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel -reading and recording temperature, pulse, and respirations of the resident -recognizing physical, emotional, cognitive, and developmental needs of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments are required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	01440		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	Continued From page 52 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 two of two unlicensed personnel (ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on November 29, 2024, to provide direct care and services to the facility's residents. On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's	01440		

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	37873	A. BUILDING: _____ B. WING _____	01/15/2025

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01440	Continued From page 53 residents. On January 13, 2025, at 3:15 p.m., the surveyor observed ULP-E administer medications to R1. ULP-D and ULP-E's employee records lacked documentation of a registered nurse (RN) supervising ULP-D and ULP-E performing a delegated task within 30 days of beginning work with the licensee. On January 15, 2025, at 9:06 a.m., licensed assisted living director (LALD)-B stated she would check in with the ULP after 30 days to discuss their performance; however, she would not observe the ULP performing delegated tasks as she was not a nurse. LALD-B stated ULP's records lacked a 30-day supervision of delegated tasks by the RN. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2024, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. It further indicated the RN would provide the direct supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 54 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470		

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01470	Continued From page 55 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-D and ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-D ULP-D was hired on November 29, 2024, to	01470		

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01470	Continued From page 56 provide direct care and services to the facility's residents. On January 14, 2025, at 8:17 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record did not include the following required orientation content: - Overview of Assisted Living statutes; - Principles of person-centered planning/service delivery; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's residents. On January 13, 20245, at 3:15 p.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record did not include the following required orientation content: - Overview of Assisted Living statutes; - Principles of person-centered planning/service delivery; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On January 15, 2025, at 9:08 a.m., licensed assisted living director (LALD)-B stated ULP-D and ULP-E's employee record lacked evidence of the required orientation as listed above. The licensee's Staff Orientation and Education	01470		

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01470	Continued From page 57 policy dated August 1, 2021, indicated orientation topics would include but not limited to, the following: a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff i. Consumer advocacy services j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	01500		

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01500	Continued From page 58 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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01500	Continued From page 59 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (owner/unlicensed personnel (O/ULP)-F). 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: O/ULP-F was hired on August 28, 2020, to provide direct care and services to the facility's residents. O/ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults or minors - Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - Review of provider's policies and procedures - Principles of person-centered planning/service delivery On January 15, 2025, at 9:10 a.m., licensed assisted living director (LALD)-B stated O/ULP-E	01500		

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01500	Continued From page 60 had not completed the required annual training as listed above. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services would complete at least eight hours of education for every twelve months of employment. Education topics would include: -Reporting of maltreatment of adults -Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights -Review of the organization's policies and procedures related to provision of assisted living services and how to implement them -Infection control techniques used in the home -Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

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01530	Continued From page 61 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-D, ULP-E, and owner (O)/ULP-F) received the required amount of dementia care training in the required time frame. 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	01530		

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01530	Continued From page 62 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an Assisted Living license. ULP-D ULP-D was hired on November 29, 2024, to provide direct care and services to the facility's residents. ULP-D's record lacked evidence of completing any dementia care training. ULP-E ULP-E was hired on November 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record contained evidence the employee received two hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. O/ULP-F O/ULP-F was hired on August 28, 2020, to provide direct care and services to the facility's residents. O/ULP-F's employee record did not include the required two hours of dementia training for each 12 months of employment in 2023. On January 15, 2025, at 9:12 a.m., licensed assisted living director (LALD)-B stated ULP-D and ULP-E worked full time (worked 160 hours since employment started) and had not	01530		

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01530	Continued From page 63 completed the required eight hours of dementia care training within 160 working hours of the employment start date. LALD-B further stated O/ULP-F's record lacked at least two hours of dementia care training for the year 2023. The licensee's Dementia Education policy dated August 1, 2021, indicated the following: 3. Direct care employees must have completed at least eight hours of initial education within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery 7. Direct care employees will complete at least two hours of education on topics related to dementia for each twelve months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01610 SS=E	144G.70 Subd. 2 (a-b) 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	01610		

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01610	Continued From page 64 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for two of two residents (R1 and R2) prior to the initiation of 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 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 July 15, 2024, with diagnoses that included diabetes. R1's Assisted Living Contract and Lease Agreement was signed by a legal representative on July 18, 2024.	01610		

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01610	Continued From page 65 R1's comprehensive Resident Intake Assessment was completed on July 18, 2024 (three days after the start of services). R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's Assisted Living Contract and Lease Agreement was signed by a legal representative on February 19, 2024. R2's comprehensive Resident Intake Assessment was completed on February 22, 2024 (three days after start of services). On January 15, 2025, at 8:24 a.m., clinical nurse supervisor (CNS)-C stated R1 and R2's initial assessments were completed after services were initiated. CNS-C stated she was not employed with the licensee at the time R1 and R2 were admitted but understood that initial assessments should be completed prior to initiation of services. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		

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01620	Continued From page 66	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment 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. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) 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 timely ongoing nursing assessments for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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CANNON COUNTRY	308 LARKSPUR LANE 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
01620	Continued From page 67 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 July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include bathing, nail and foot care, skin care, standby assistance, meal assistance, homemaker services, monthly vital signs, blood glucose monitoring and medication administration. R1's assessments dated August 20, 2024, and January 11, 2025, were reviewed. The August 20, 2024, assessment was completed 33 days after the date of admission, thus exceeding the required reassessment at 14 calendar days. The January 11, 2025, assessment was completed 144 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include dressing, bathing, nail and foot care, skin care,	01620		

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01620	Continued From page 68 toileting, supervision with ambulation, meal assistance, monthly vital signs, blood glucose monitoring and medication administration. R2's assessments dated May 27, 2024, August 28, 2024, and January 11, 2025, were reviewed. The May 27, 2024, assessment was completed 98 days after the date of admission, thus exceeding the required reassessment at 14 calendar days and the ongoing assessments not to exceed 90 days. The August 28, 2024, assessment was completed 93 days after the date of the previous assessment, and the January 11, 2025, assessment was completed 136 days after the date of the previous assessment, thus exceeding 90 calendar days. On January 15, 2025, at 8:27 a.m., clinical nurse supervisor (CNS)-C stated R1 and R2's assessments were not completed within the required time frame. CNS-C stated she was in the process of auditing all resident assessments to ensure they were completed timely going forward. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last assessment date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 69 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01640		

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01640	Continued From page 70 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. On January 13, 2025, at 3:25 p.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include bathing, nail and foot care, skin care, standby assistance, meal assistance, homemaker services, monthly vital signs, blood glucose monitoring and medication administration. R1's prescriber orders dated July 12, 2024, included: -Blood glucose monitoring; obtain blood sugar via meter and record results before meals and at bedtime. R1's Medication and Treatment Record dated January 2025, did not include blood glucose monitoring. On January 13, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-C stated the licensee no longer checked R1's blood glucose. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain.	01640		

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01640	Continued From page 71 On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated February 19, 2024, indicated R2 received services to include dressing, bathing, nail and foot care, skin care, toileting, supervision with ambulation, meal assistance, monthly vital signs, blood glucose monitoring (four times a day) and medication administration. R2's Medication and Treatment Record dated January 2025, indicated R2's blood glucose was checked once a day at bedtime. R2's Services Charting Sheet dated January 2025, did not include dressing, nail care and foot care, skin care, toileting, supervision with ambulation, or meal assistance. On January 15, 2025, at 8:28 a.m., CNS-C stated R2 previously required assistance with the services listed above but was now independent with them. CNS-C further stated R1 and R2's service plans did not accurately reflect the current services being provided to them. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and all revisions were entered into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 72 (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 licensee failed to ensure the service plan included all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01650		

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01650	Continued From page 73 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: R1 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include bathing, nail and foot care, skin care, standby assistance, meal assistance, homemaker services, monthly vital signs, blood glucose monitoring and medication administration. R1's service plan lacked the following content: -the fees for services; and the frequency of each service; -identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and 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 and information as to who has authority to sign for the resident in an emergency	01650		

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01650	Continued From page 74 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 R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include dressing, bathing, nail and foot care, skin care, toileting, supervision with ambulation, meal assistance, monthly vital signs, blood glucose monitoring and medication administration. R2's service plan lacked the following content: -the fees for services; and the frequency of each service; -identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and 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 and information as to who has authority to sign for the resident in an emergency and -the circumstances in which emergency	01650		

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01650	Continued From page 75 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On January 15, 2025, at 8:34 a.m., licensed assisted living director (LALD)-B stated R1 and R2 had different versions of the service plan and neither included the required content as listed above. LALD-B further stated all residents had one of the versions the surveyor reviewed (as noted above). The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following: a. a description of the services to be provided; the service description ay be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff providing services f. A contingency plan that includes the following i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or resident's representative to contact the facility iii. Names and contact information of person the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition. iv. The identification of the information as to who has the authority to sign for the resident in an	01650		

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01650	Continued From page 76 emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	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 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,	01700		

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01700	Continued From page 77 theft, or illegal or improper disposition of medications. 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 a face-to-face medication management assessment to include all required content for two of two residents (R1 and R2) 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 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: During the entrance conference on January 13, 2025, at 9:15 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the residents of the facility. R1 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. On January 14, 2025, at 8:17 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's unsigned, Service Plan and Home Health Aide Interventions document dated July 18, 2024,	01700		

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01700	Continued From page 78 indicated R1 received services to include medication administration. R1's signed prescriber orders dated July 12, 2024, included: -alendronate sodium 70 milligrams (mg): give 70 mg by mouth one time a day every Friday. -Ammonium Lactate External Cream 12%; apply to affected area topically two times a day -aspirin 81 mg; give 81 mg by mouth one time a day -atorvastatin calcium; 80 mg; give 80 mg by mouth one time a day -clopidogrel bisulfate 75 mg; give 75 mg by mouth one time a day -cyanocobalamin 1,000 micrograms (mcg); give one tablet by mouth one time a day -docusate sodium 100 mg; give 100 mg by mouth as needed twice a day -famotidine 20 mg; give 20 mg by mouth one time a day -ferrous sulfate 325 mg; give 325 mg by mouth one time a day every other day -hydroxyzine HCL 100 mg; give 100 mg by mouth at bedtime -hydroxyzine HCL 50 mg; give 50 mg by mouth two times a day -insulin Lispro injection solution 100 units/milliliter (ml); Inject per sliding scale before meals: -Blood Glucose (BG) 151-200= give 2 units -BG 201-250 = give 4 units -BG 251-300 = give 6 units -BG 301-350 = give 8 units -BG 351-400 = give 10 units -BG 401-450 = give 12 units -BG 451-600 = give 14 units -BG 501 or above notify provider -Lantus Solostar 100 units/ml; Inject 20 units subcutaneously at bedtime -magnesium oxide 400 mg; give 400 mg by	01700		

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01700	Continued From page 79 mouth two times a day -meclizine 25 mg; give 25 mg by mouth every six hours as needed for dizziness. -metformin 500 mg; give 2,000 mg by mouth one time a day -pramipexole dihydrochloride 1 mg; give 1 mg by mouth at bedtime -senexon-S 8.6-50 mg; give one tablet by mouth as needed for constipation 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. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. On January 14, 2025, at 8:50 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated February 19, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders dated November 5, 2024, included the following: -acetaminophen 500 mg; take two tablets (=1,000 mg) by mouth four times a day if needed for pain -albuterol sulfate 108 (90 base) microgram(mcg)/ACT; Inhale 1-2 puffs every four hours if needed for wheezing	01700		

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01700	Continued From page 80 -buspirone 10 mg; take one tablet by mouth one time a day -carvedilol 25 mg -clopidogrel bisulfate 75 mg; take one tablet by mouth every day -clotrimazole cream 1%; apply topically two times a day if needed for rash -cyclobenzaprine 5 mg; take one tablet by mouth three times a day as needed -duloxetine 60 mg; take one capsule by mouth one time each day -famotidine 40 mg; take one tablet by mouth every night -flecainide acetate 100 mg; take one tablet by mouth two times a day -Blood glucose; Accu-Chek test strips to be used four times a day -Lanus Solostar 100 units/ml; Inject 15 units under the skin every night before bed -ipratropium-albuterol 0.5-2.5 mg/3 ml; take 3 ml by nebulization four times a day if needed for wheezing -losartan potassium 100 mg; take one tablet by mouth every night -meclizine 25 mg; take 0.5 tablets (=12.5 mg) by mouth three times a day if needed for dizziness -melatonin 5 mg; take one tablet by mouth at night if needed for sleep -oxycodone 10 mg; take one tablet by mouth every 8 hours as needed for pain -rosuvastatin 20 mg; take one tablet by mouth one time a day -triamcinolone acetonide 0.1%; apply topically at night if needed for cracked skin heel. R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In	01700		

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	37873	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01700	Continued From page 81 addition, R2'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. On January 15, 2025, at 8:36 a.m., CNS-C reviewed R1's initial medication management assessment dated July 18, 2024, and stated the required content as noted above had not been included in the assessment. CNS-C reviewed R2's initial mediation management assessment dated February 22, 2024, and stated the required content as noted above had not been included in the assessment. Licensed assisted living director (LALD)-B stated the same medication assessment was used for all residents. The licensee's Medication Management Program policy, undated, indicated the medication management program is at the discretion of the RN and based on a professional face-to-face nursing assessment that includes the following elements: 1. Resident, resident's designated representative and/or resident's legal representative ability in medication self-management. 2. Home environment: safety and sanitation 3. Storage/security of medications 4. Coordination/communication with prescriber and other providers involved with medication management 5. Medication reconciliation to include: a. Indication for medication b. Effectiveness of drug therapy c. Side effects d. Immediate desired effects e. Unusual and unexpected effects f. Actual or potential drug interactions	01700		

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01700	Continued From page 82 g. Duplicate drug therapy h. Non-adherence with drug therapy i. Drug therapy currently associated with laboratory monitoring j. Allergic reactions k. Changes in condition that contraindicate continued administration of the medication No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 83 (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 two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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	01730		

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01730	Continued From page 84 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. On January 14, 2025, at 8:17 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include medication administration. R1's signed prescriber orders dated July 12, 2024, included: -alendronate sodium 70 milligrams (mg): give 70 mg by mouth one time a day every Friday. -Ammonium Lactate External Cream 12%; apply to affected area topically two times a day -aspirin 81 mg; give 81 mg by mouth one time a day -atorvastatin calcium; 80 mg; give 80 mg by mouth one time a day -clopidogrel bisulfate 75 mg; give 75 mg by mouth one time a day -cyanocobalamin 1,000 micrograms (mcg); give one tablet by mouth one time a day -docusate sodium 100 mg; give 100 mg by mouth as needed twice a day -famotidine 20 mg; give 20 mg by mouth one time a day -ferrous sulfate 325 mg; give 325 mg by mouth one time a day every other day -hydroxyzine HCL 100 mg; give 100 mg by mouth at bedtime -hydroxyzine HCL 50 mg; give 50 mg by mouth two times a day -insulin Lispro injection solution 100 units/milliliter (ml); Inject per sliding scale before meals: -Blood Glucose (BG) 151-200= give 2 units -BG 201-250 = give 4 units	01730		

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01730	Continued From page 85 -BG 251-300 = give 6 units -BG 301-350 = give 8 units -BG 351-400 = give 10 units -BG 401-450 = give 12 units -BG 451-600 = give 14 units -BG 501 or above notify provider -Lantus Solostar 100 units/ml; Inject 20 units subcutaneously at bedtime -magnesium oxide 400 mg; give 400 mg by mouth two times a day -meclizine 25 mg; give 25 mg by mouth every six hours as needed for dizziness. -metformin 500 mg; give 2,000 mg by mouth one time a day -pramipexole dihydrochloride 1 mg; give 1 mg by mouth at bedtime -senexon-S 8.6-50 mg; give one tablet by mouth as needed for constipation R1's record lacked an Individualized Medication Management Plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 86 - 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. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. On January 14, 2025, at 8:50 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated February 19, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders dated November 5, 2024, included the following: -acetaminophen 500 mg; take two tablets (=1,000 mg) by mouth four times a day if needed for pain -albuterol sulfate 108 (90 base) mcg/ACT; Inhale 1-2 puffs every four hours if needed for wheezing -buspirone 10 mg; take one tablet by mouth one time a day -carvedilol 25 mg -clopidogrel bisulfate 75 mg; take one tablet by mouth every day -clotrimazole cream 1%; apply topically two times a day if needed for rash -cyclobenzaprine 5 mg; take one tablet by mouth three times a day as needed -duloxetine 60 mg; take one capsule by mouth one time each day -famotidine 40 mg; take one tablet by mouth every night -flecainide acetate 100 mg; take one tablet by mouth two times a day	01730		

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01730	Continued From page 87 -Blood glucose; Accu-Chek test strips to be used four times a day -Lanus Solostar 100 units/ml; Inject 15 units under the skin every night before bed -ipratropium-albuterol 0.5-2.5 mg/3 ml; take 3 ml by nebulization four times a day if needed for wheezing -losartan potassium 100 mg; take one tablet by mouth every night -meclizine 25 mg; take 0.5 tablets (=12.5 mg) by mouth three times a day if needed for dizziness -melatonin 5 mg; take one tablet by mouth at night if needed for sleep -oxycodone 10 mg; take one tablet by mouth every 8 hours as needed for pain -rosuvastatin 20 mg; take one tablet by mouth one time a day -triamcinolone acetonide 0.1%; apply topically at night if needed for cracked skin heel. R2's record lacked an Individualized Medication Management Plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management	01730		

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01730	Continued From page 88 services; and - 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. On January 15, 2025, at 8:38 a.m., clinical nurse supervisor (CNS)-C stated R1 and R2's record lacked a individualized medication management plan. The licensee's Medication Management Program policy, undated, indicated the following services were included in the medication management program: -performing medication setup -administering medications -storing and securing medications -documenting medication activities -verifying and monitoring the effectiveness to ensure safe handling and administration -coordinating refills -handing and implementing changes to prescriptions -communicating with the pharmacy about the resident's medications -coordinating and communicating with the prescriber No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 89 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R2) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include medication administration.	01750		

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01750	Continued From page 90 On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. R2's signed prescriber orders dated November 5, 2024, included: -albuterol sulfate 108 (90 base) micrograms (mcg)/ACT; inhale one to two puffs every four hours as needed for wheezing. The licensee failed to have resident-specific instructions regarding when one puff or two puffs of albuterol sulfate would be given. On January 15, 2025, at 8:39 a.m., clinical nurse supervisor (CNS)-C stated there were no specific instructions regarding the dose for R2's albuterol sulfate order. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated medication orders would include the name of the medication, dosage, and direction for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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	01760		

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01760	Continued From page 91 administration. The staff must document the 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 documentation included the effectiveness for as needed (PRN) medication administration for one of two residents (R2) was completed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. On January 13, 2025, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's service plan dated February 19, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders dated November 5,	01760		

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01760	Continued From page 92 2024, included: -meclizine 25 mg; take 0.5 tablets (=12.5 mg) by mouth three times a day if needed for dizziness -melatonin 5 mg; take one tablet by mouth at night if needed for sleep R2's Medication Administration Record (MAR) dated January 2025, indicated the following: -R2 received meclizine twice on January 10, 2025. -R2's record lacked documentation of PRN effectiveness for one of the administrations. -R2 received melatonin on January 1, 3, 7, 10, 11, and 12, 2025. -R2's record lacked documentation of PRN effectiveness for three of the administrations. On January 15, 2025, at 8:39 a.m., clinical nurse supervisor (CNS)-C stated R2's record lacked documentation of PRN effectiveness for all PRN medications administered to R2. CNS-C further stated staff were expected the ULP to document PRN effectiveness for all PRN medications administered. The licensee's Medication Administration Review policy, undated, indicated for all PRN medications, the ULP would document if a PRN medication was effective or not effective. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 93 recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 July 15, 2024, with diagnoses that included diabetes. On January 14, 2025, at 8:17 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include medication administration. FAMOTIDINE:	01820		

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CANNON COUNTRY	308 LARKSPUR LANE CANNON FALLS, MN 55009

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01820	Continued From page 94 -R1's Medication Administration Record (MAR) dated January 2025, included famotidine 20 milligrams (mg); give 20 mg by mouth twice a day. -R1's prescriber orders dated July 12, 2024, included famotidine 20 mg; give 20 mg by mouth one time a day. R1's record lacked prescriber orders to administer famotidine 20 mg twice a day. METFORMIN: R1's MAR dated January 2025, included Metformin 500 mg; give Metformin 1,000 mg by mouth twice a day. R1's prescriber orders dated July 12, 2024, included Metformin 500 mg; give 2,000 mg by mouth one time a day. R1's record lacked prescriber orders to administer metformin 1,000 mg twice a day instead of metformin 2,000 mg one time a day. ASPIRIN: -R1's MAR included aspirin 81 mg; give 81 mg once a day -R1's prescriber orders dated July 12, 2024, included aspirin 81 mg; take 81 mg by mouth once a day. On January 14, 2025, at 8:17 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer aspirin 325 mg to R1. R1's record lacked prescriber orders to administer aspirin 325 mg once a day. R1's MAR dated January 2025, included the following medications: -Jardiance 10 mg; give 10 mg by mouth once a day -amlodipine 5 mg; give 5 mg by mouth once a day	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE CANNON FALLS, MN 55009

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01820	Continued From page 95 -ondansetron 8 mg; give 8 mg by mouth every eight hours as needed for nausea/vomiting R1's record lacked signed prescriber orders for the medications listed above. R1's prescriber orders dated July 12, 2024, included: -meclizine 25 mg; take 25 mg by mouth every six hours as needed for dizziness. -Lantus Solostar 100 units/milliliter (ml); inject 20 units subcutaneously at bedtime. -insulin Lispro injection solution 100 units/milliliter (ml); Inject per sliding scale before meals: -Blood Glucose (BG) 151-200= give 2 units -BG 201-250 = give 4 units -BG 251-300 = give 6 units -BG 301-350 = give 8 units -BG 351-400 = give 10 units -BG 401-450 = give 12 units -BG 451-500 = give 14 units -BG 501 or above notify provider -clopidogrel bisulfate 75 mg; give 75 mg by mouth one time a day R1's MAR dated January 2025, did not include orders for the medications listed above. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include medication administration. On January 13, 2025, at 12:45 p.m., the surveyor observed ULP-D administer medications to R2. CYCLOBENZAPRINE: -R2's MAR dated January 2025, included	01820		

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01820	Continued From page 96 cyclobenzaprine 5 mg; give 5 mg by mouth three times a day scheduled -R2's prescriber orders dated November 5, 2024, included cyclobenzaprine 5 mg; give 5 mg by mouth three times a day as needed (PRN). R2's record lacked prescriber orders to schedule cyclobenzaprine three times a day instead of PRN. ACETAMINOPHEN: -R2's MAR dated January 2025, included acetaminophen 500 mg; take two tablets (=1,000 mg) by mouth four times daily for pain. -R2's prescriber orders dated November 5, 2024, included acetaminophen 1,000 mg; give 1,000 mg by mouth four times a day as needed for pain. R2's record lacked prescriber orders to schedule acetaminophen four times a day instead of PRN. MECLIZINE: -R2's MAR dated January 2025, included meclizine 25 mg; give 25 mg by mouth three times a day as needed for dizziness -R2's prescriber orders dated November 5, 2025, included meclizine 25 mg; take one-half tablet (=12.5 mg) by mouth three times a day as needed for dizziness. R2's record lacked prescriber orders to administer meclizine 25 mg instead of 12.5 mg. AMLODIPINE BESYLATE: R2's MAR dated January 2025, included amlodipine besylate 5 mg; take 5 mg by mouth twice a day R2's record lacked prescriber orders for amlodipine besylate. On January 15, 2025, at 8:55 a.m., clinical nurse supervisor (CNS)-C stated R1 and R2's record lacked current prescriber orders for the	01820		

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01820	Continued From page 97 medications listed above. CNS-C stated another nurse previously checked the MARs for accuracy and stated the orders on the MAR are correct, they just didn't have all prescriptions in the resident record. CNS-C further stated she was newly hired to the facility and was unsure why the prescriber orders were not in R1 and R2's record. CNS-C stated both R1 and R2 have upcoming appointments with their primary care provider to clarify medications and obtain current prescriber orders for all medications and treatments being administered. The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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;	01940		

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01940	Continued From page 98 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	01940		

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01940	Continued From page 99 R1 R1 was admitted on July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include blood glucose monitoring. The service plan did not include weekly weights. R1's Medication and Treatment Record dated January 2025, indicate R1's weight was checked once a week on Friday mornings. R1's prescriber orders dated July 12, 2024, included: -Blood glucose monitoring; obtain blood sugar via meter and record results before meals and at bedtime. On January 13, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-C stated the licensee no longer checked R1's blood glucose. CNS-C stated the facility checked monthly vital signs and weights on all residents, anything more frequently required a prescriber order. R1's record lacked prescriber orders for weekly weights. R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 100 appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include blood glucose monitoring four times a day. R2's Medication and Treatment Record dated January 2025, indicated R2's blood glucose was checked once a day at bedtime. R2's prescriber orders dated November 5, 2024, included: -AccuCheck to be used four times a day when checking blood glucose R2's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 101 problem arises with treatments or therapy services; and - 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. On January 15, 2025, at 8:42 a.m., CNS-C stated R1 and R2's record lacked individualized treatment management plans to include the required content as listed above. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addressed: - type of service to be provided - procedures for documenting treatments or therapies - procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions - identification of treatment or therapy tasks delegated to unlicensed personnel - procedures for notifying the RN when a problem arises related to the treatment or therapy service No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 102 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 interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1 and R2) 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 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 July 15, 2024, with diagnoses that included diabetes. R1's Service Plan and Home Health Aide Interventions document dated July 18, 2024, indicated R1 received services to include blood glucose monitoring. The service plan did not include weekly weights.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 103 R1's Medication and Treatment Record dated January 2025, indicate R1's weight was checked once a week on Friday mornings. R1's prescriber orders dated July 12, 2024, included: -Blood glucose monitoring; obtain blood sugar via meter and record results before meals and at bedtime. R1's record lacked prescriber orders for weekly weights. On January 13, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-C stated the licensee no longer checked R1's blood glucose. CNS-C stated R1's record lacked an order to discontinue blood glucose checks. CNS-C stated the facility checked monthly vital signs and weights on all residents, anything more frequently required a prescriber order. CNS-C stated R1's record did not include an order for weekly weights. R2 R2 was admitted on February 19, 2024, with diagnoses that included diabetes and chronic pain. R2's service plan dated February 19, 2024, indicated R2 received services to include blood glucose monitoring four times a day. R2's Medication and Treatment Record dated January 2025, indicated R2's blood glucose was checked once a day at bedtime. R2's prescriber orders dated November 5, 2024, included: -AccuCheck to be used four times a day when	01970		

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01970	Continued From page 104 checking blood glucose R2's record lacked prescriber orders to decrease blood glucose checks to once a day at bedtime. On January 15, 2025, at 8:46 a.m., CNS-C stated R2's record lacked prescriber orders for once a day blood glucose checks. CNS-C further stated R2 had an upcoming appointment with her primary care provider and would request clarification on blood glucose checks. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) would obtain orders or prescriptions for all treatments ant therapies. The order would include the following elements: -resident name -description of the treatment or therapy to be provided -frequency -other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *01/13/25*
Time: 13:57:02
Report: 7962251005

Food and Beverage Establishment Inspection Report

Location:
Cannon Country
308 Larkspur Lane
Cannon Falls, MN55009
Goodhue County, 25

Establishment Info:
ID #: 0040331
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #: 5072988857
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-100 Food Characteristics: unadulterated

3-101.11 ***** Priority 1 *****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

WHITE CUPBOARD IN GARAGE WITH FOOD; OATMEAL, CAKE MIX, RITZ, CANS OF SOUP, RODENT POOP, PER MANAGER FOOD IS OLD AND NOT FOR RESIDENTS, WILL DISCARD ALL IMMEDIATELY

Comply By: 01/13/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS ON TOP OF READY TO EAT FOOD, MOVED TO BOTTOM SHELF

Comply By: 01/13/25

3-500A Microbial Control: cooling

3-501.14A ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

CASSEROLE ON COUNTER, COOK DID NOT KNOW WHEN THE CASSEROLE WAS REMOVED FROM THE OVEN, CASSEROLE RETURNED TO THE OVEN TO REHEAT TO 165 DEGREES,

TEMPERATURE TAKEN AT END OF INSPECTION 123 DEGREES
Comply By: 01/13/25

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

WHITE DOMESTIC REFRIGERATOR; LOWER; SOUR CREAM 42DF, SOUR CREAM 43DF, INSPECTOR THERMOMETER 43DF, INDEPENDENT THERMOMETER 43DF, ALL TCS FOOD MOVED TO SILVER DOMESTIC REFRIGERATOR UNTIL WHITE FRIG HOLDS 41DF OR LOWER
Comply By: 01/13/25

4-600 Cleaning Equipment and Utensils
4-602.11A ***** Priority 1 *****
MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

COOK HAD NO MEANS TO SANITIZE THERMOMETER, GOT ALCOHOL SWABS FROM MEDICINE CABINET
Comply By: 01/13/25

2-100 Supervision
2-103.11B ***** Priority 2 *****
MN Rule 4626.0035B The person in charge must ensure only authorized persons are permitted in food preparation, food storage, and warewashing areas of the establishment.

VISITOR WITH DOG WALKED THROUGH KITCHEN SEVERAL TIMES
Comply By: 01/13/25

2-100 Supervision
2-103.11DGHIKM ***** Priority 2 *****
MN Rule 4626.0035DGHIKM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.

Comply By: 01/13/25

4-200 Equipment Design and Construction

4-203.12 ***** Priority 2 *****

MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

PAPER TEMPERATURE MEASURER FOR DISH WASHING MACHINE ARE NOT ACCURATE TO PLUS OR MINUS 3 DEGREES, PICTURES OF IRREVERSIBLE THERMOMETERS SENT WITH REPORT

Comply By: 01/20/25

2-400 Hygenic Practices

2-402.11

MN Rule 4626.0115 Food employees must wear an effective hair restraint, such as a hat, hair covering or hair net, a beard restraint and clothing to keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.

NO HAIR RESTRAINT WORN

Comply By: 01/13/25

4-400 Equipment Location and Installation

4-402.12A

MN Rule 4626.0730A Install floor-mounted equipment sealed to the floor or on six inch legs.

GARAGE FREEZER NOT ELEVATED, NO CASTERS, NOT SEALED TO FLOOR

Comply By: 01/20/25

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

ITEMS ON FLOOR IN DRY STORAGE ROOM

Comply By: 01/13/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

RODENT DROPPINGS IN GARAGE, FREEZER WITH FOOD STORAGE IN GARAGE, GARBAGE CAN TOO FULL TO CLOSE LID, LOTS OF MISCELLANEOUS ITEMS

Comply By: 01/13/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

GARAGE FULL OF OF MISCELLANEOUS ITEMS, UNUSED CHEST FREEZER

Comply By: 01/13/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

RODENT DROPPINGS IN GARAGE, FREEZER WITH FOOD STORAGE IN GARAGE, GARBAGE CAN TOO FULL TO CLOSE LID, LOTS OF MISCELLANEOUS ITEMS

Comply By: 01/13/25

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit
Location: bleach spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: silver refrigerator gallon milk
Violation Issued: No

Process/Item: Domestic Refrigerator
Temperature: 42 Degrees Fahrenheit - Location: white refrigerator small sour cream container
Violation Issued: Yes

Process/Item: Domestic Refrigerator
Temperature: 43 Degrees Fahrenheit - Location: white refrigerator large sour cream container
Violation Issued: Yes

Process/Item: Domestic Refrigerator
Temperature: 43 Degrees Fahrenheit - Location: white refrigerator inspector thermometer
Violation Issued: Yes

Process/Item: Re-Heating
Temperature: 123 Degrees Fahrenheit - Location: cicken casserole reheating in oven to 165 degrees, temperature taken at end of inspection
Violation Issued: No

Process/Item: Cooling from Hot Temperatu
Temperature: 103 Degrees Fahrenheit - Location: casserole on counter, cook did not know when the casserole was removed from the oven
Violation Issued: Yes

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		5	3	6

eggs moved to bottom shelf

Establishment Info:
6-13-24

*FLOORS ARE LAMINATE WOOD, WALLS ARE PAINTED DRY WALL, AND CEILING IS TEXTURED. COUNTERTOPS CONSIST OF STONE AND WOOD AND CABINETS ARE HOLLOW BASE LACQUERED WOOD. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962251005 of 01/13/25.

Certified Food Protection Manager: Ashlyn Hallman

Certification Number: FM109506 Expires: 01/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ashlyn Hallman
LALD

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Report #: 7962251005

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul

No. of RF/PHI Categories Out	6
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/13/25
Time In 13:57:02
Time Out

	Address	City/State	Zip Code	Telephone
Cannon Country	308 Larkspur Lane	Cannon Falls, MN	55009	5072988857

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0040331		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	IN	(OUT)			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	IN	(OUT)			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	(OUT)	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	(OUT)	N/A	N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O	Proper hot holding temperatures		
22	IN	(OUT)	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38	X	Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40	X	Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44	X	Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/15/25

Inspector (Signature) Hunter Flueger