Electronically Delivered

February 27, 2026

Licensee
Riverside Assisted Living
812 Centre Street East
Royalton, MN 56373

RE: Project Number(s) SL30537016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30537	A. BUILDING: _____ B. WING _____	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30537016 On February 9, 2026, through February 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 12 residents; all 12 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	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 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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel/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	0 660		

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0 660	Continued From page 4 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: The licensee's Facility TB Risk Assessment dated May 15, 2025, indicated the licensee was a low risk level. ULP-F was hired on May 26, 2022, to provide direct care services to the licensee's residents. On February 10, 2026, at 7:05 a.m., the surveyor observed ULP-F administer medications to R1. ULP-F's record included a two-step TST as follows: - First step administered on June 24, 2022, and read on June 27, 2022, with the number of millimeters (mm) of induration as zero (0), and the interpretation as negative; - Second step administered on July 12, 2022, and read on July 14, 2022. However, the mm induration and interpretation were left blank. On February 11, 2026, at 10:35 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated it appeared this got missed and should have been filled in. The licensee's Tuberculosis & Staff Screening policy dated May 27, 2025, noted new personnel would have a two-step TST conducted and the results would be documented. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control	0 660		

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0 660	Continued From page 5 in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated TST documentation should include the date of the test, the number of mm induration (if no induration, document 0 mm) and the interpretation (positive or negative). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 775		

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0 775	Continued From page 6 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 775		
0 800 SS=F	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 800		

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0 800	Continued From page 7 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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 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	0 810		

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0 810	Continued From page 8 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 810		

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0 830	Continued From page 9	0 830		
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all 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, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of five residents (R4, R5, R7). 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: On February 9, 2026, at 12:30 p.m., upon arriving at the facility, the surveyor observed a tall cigarette receptacle for residents to place finished cigarettes in them outside the front door.	0 830		

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0 830	Continued From page 10 On February 10, 2026, at 10:45 a.m., the surveyor observed with assisted living director in residency (ALDIR)-C R4's room. R4 was sitting in a chair in the middle of the room watching television. The bedside table next to the chair had a pipe, soda cans, snacks, a paper cup, and loose tobacco on it. The window sill behind the chair had ashes and burnt tobacco on it as well as on two books on the window sill which had ashes and tobacco on them. Below the window was a cardboard box with movies in it. Ashes were also noted on the cardboard box. The toilet in the bathroom had ashes around the rim of the toilet and there was a cooking kettle on the toilet tank cover with tobacco and ashes in it. When asked if he smoked in his room, R4 said "God no, that would stink up the whole place." The surveyor and ALDIR-C noted a burn hole on the top side of R4's pants he was wearing. R4 R4's diagnoses included acute respiratory failure, hypothyroidism, and lupus. R4's Assessment dated January 27, 2026, noted R4 lit and extinguished the cigarette responsibly and completely, there were no signs in the apartment of mishandled cigarettes, and the resident was able to smoke safely, independently, and without intervention. R4's Service Plan dated October 29, 2025, indicated R4 received services including assistance with bathing, behavior management, housekeeping, and medication administration. R4's Resident Notes included the following: - November 14, 2025, at 11:53 a.m. - staff entered R4's room and saw him leaning out the	0 830		

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0 830	Continued From page 11 window gagging. R4 said he was looking at the wildlife; - November 21, 2026, at 5:23 a.m. - staff found R4 hanging out of his window smoking; and - January 20, 2026, at 12:16 p.m. - staff observed R4 standing in the entryway smoking with the door cracked and blowing the smoke out the door. Staff told R4 he could not smoke in the entryway and R4 replied he was looking outside. On February 10, 2026, at 10:37 a.m., clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-I stated they were not sure if R4 smoked in his room. CNS-A looked back in the progress notes and said she did not see anything regarding smoking. After the surveyor requested resident notes from the past year and found entries about smoking, CNS-A stated she did review the notes as a part of doing the assessments, but must have missed this. R5 R5's diagnoses included diabetes mellitus type 2 and atrial fibrillation. R5's Assessment dated January 27, 2026, noted R5 lit and extinguished the cigarette responsibly, and there were no signs of burning on the resident's clothing. It noted the resident was able to smoke safely, independently, and without intervention. R5's Service Plan dated December 8, 2025, indicated R5 received services including assistance with housekeeping, meal attendance, and medication administration. R5's Resident Notes include the following: - November 18, 2025, at 12:24 a.m. - staff smelled a burning smell in the hallway. When	0 830		

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0 830	Continued From page 12 entering R5's room the smell was very strong. R5 stated their pants started on fire, and he didn't know the cherry from his cigarette fell onto his pants. A large hole was noted on the bottom of R5's left pant leg and through to the sock. Staff did not notice any visible burns at that time; and - January 28, 2026, at 11:34 a.m. - Staff noted burn marks on R4's jacket from cigarettes and noted R5 was aware he had some burn marks on his clothing. CNS-A and ALDIR-C spoke to resident regarding safety. CNS-A noted resident was able to light cigarette and dispose of the cigarette safely. It noted a plan to order a smoking apron and provide staff supervision until the apron is delivered. On February 12, 2026, at 11:45 a.m., CNS-A stated R5's sister was supposed to order the smoking apron but had not done so yet and the county would not pay for it. CNS-A said the licensee is ordering the smoking apron now. In addition, CNS-A stated R5 is supervised when he goes outside, and there is a button on the door that sounds if not pushed before opening the door, and R5 does not push the button, so staff know when he goes out. R7 R7's diagnoses included schizophrenia, chronic congestive heart failure, and chronic obstructive pulmonary disease. R7's Assessment dated November 21, 2025, noted R7 lit and extinguished the cigarette responsibly, there were no signs of burning on the resident's clothing, and resident was able to smoke safely, independently, and without intervention. R7's Service Plan dated November 11, 2025,	0 830		

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0 830	Continued From page 13 indicated R7 received services including assistance with bathing, behavior management, dressing, and medication administration. R7's Resident Notes included the following: - October 28, 2025, at 10:33 a.m. - R7 continues to light his smoke in the entryway, creating a large cloud of smoke; - December 3, 2025, at 12:14 p.m. - Staff found R7 lighting his pipe in the entryway; and - January 9, 2026, at 9:59 p.m. - staff caught R7 lighting his pipe and taking a couple puffs in the entryway. On February 12, 2026, at 11:58 a.m., CNS-A stated R7 was not smoking in the entryway, but just lighting the pipe before he goes outside. CNS-A added smoking is not allowed in the building. The licensee's Resident Handbook notes all sites are tobacco free and smoking is not permitted in the living units or anywhere else inside the building. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a)	0 830		

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0 830	Continued From page 14 Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies	01290		

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01290	Continued From page 15 were affiliated with their health facility identification (HFID) for one of four employees (registered nurse/RN-D).This had the potential to affect all residents living within 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 9, 2026, at 12:30 p.m., licensed assisted living director (LALD)-B, clinical nurse supervisor (CNS)-A, and assisted living director in residency (ALDIR)-C stated the licensee was aware of the required contents of an employee records. RN-D was hired on October 26, 2015, to provide direct care services to residents and to provide staff supervision at the facility. RN-D's record included a background study clearance letter dated July 14, 2021, submitted through a separate license of an affiliated company. On February 10, 2026, at 2:45 p.m., ALDIR-C stated RN-D was not affiliated with this HFID prior to today, and should be affiliated since she does come to this facility and covers for the CNS. The licensee's Background Checks policy dated August 1, 2021, noted the licensee would initiate	01290		

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01290	Continued From page 16 a background study on all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if	01530		

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01530	Continued From page 17 issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; 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 (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-E) 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 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility held an assisted living license effective January 1, 2026. During the entrance conference on February 9, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A and assisted living director in residency	01530		

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01530	Continued From page 18 (ALDIR)-C stated they were aware of the required contents of the employee records. CNS-A CNS-A was hired on February 20, 2025, to provide direct care services to residents and to provide staff supervision at the facility. Throughout the survey, CNS-A was observed interacting with the licensee's residents. CNS-A's record included a transcript with 7.75 hours dementia training (4.584 hours run time), short of the 8.0 hours required. ULP-E ULP-E was hired on April 3, 2025, to provide direct care services to residents. On February 10, 2026, at 8:35 a.m., the surveyor observed ULP-E offer assistance with cares to R1. ULP-E's record included a transcript with 7.75 hours dementia training (4.584 hours run time), short of the 8.0 hours required. On February 11, 2026, at 10:41 a.m., licensed assisted living director (LALD)-B stated she would look for a master copy of the actual hours for dementia training, which showed the actual hours of run time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 19	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 20 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess residents after a fall and develop and implement new interventions related to the root cause of falls for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3's diagnoses included anxiety disorder, anemia, atrial fibrillation, chronic kidney disease, hypertension, macular degeneration, and frequent falls. R3 admitted to the facility on February 19, 2025, and discharged on October 13, 2025, upon her	01620		

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01620	Continued From page 21 death. R3's Service Plan dated June 30, 2025, indicated R3 received services including assistance with ambulation, bathing, behavior management, and medication administration. R3's Incident Reports noted the following: - August 10, 2025, at 2:30 a.m., resident had a fall in her bedroom trying to get out of bed to use the bathroom, and hit her head. R3 sustained a hematoma on her scalp. Interventions noted by nursing included staff to assist as needed; - August 19, 2025, at 12:15 a.m., R3 was found on the floor next to her bed during safety checks. R3 stated she slid out of bed when trying to get to the bathroom. Interventions noted by nursing included reminding R3 to use her walker, having the walker near resident, and to wear non-skid gripper socks at night; - R3's Fall Risk Assessment dated August 19, 2025, noted a score of 8, indicating a risk for falls. It noted "Resident is at risk for falls as indicated by the fall risk assessment score related to age, diagnoses, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed PT [physical therapy] will be initiated PRN [as needed]. Safety checks. Service to remind resident to use walker and have walker placed by resident. Staff to assist as needed with ambulation or transfers. Resident to wear non slip socks at night."; - August 20, 2025, at 6:00 a.m., R3 came to the dining room and told staff she fell, hitting her head on the stool in her room and was not sure what caused the fall. Interventions included furniture placement, had family remove the stool, and encouraged R3 to use gripper socks; - R3's Assessment dated August 25, 2025,	01620		

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01620	Continued From page 22 noted R3 required daily reminders to use her walker for all ambulation, she had recent attempts to leave the facility due to confusion, and under the fall risk summary noted "Resident is at risk for falls as indicated by fall risk assessment score related to age, diagnoses, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed. PT will be initiated PRN. Safety checks. Service to remind resident to use walker and have walker placed by resident. Staff to assist as needed with ambulation or transfers. Resident to wear non slip gripper socks at night." Fall score was 8; - August 31, 2025, at 7:00 a.m., R3 fell in the public bathroom and was hollering for help. R3 stated she lost her balance when trying to use the toilet and slipped. Interventions included assist as needed, wearing the pendant around her neck to call for help and was reminded to use it, and on safety checks every two hours (all residents were on two hour safety checks); - September 5, 2025, at 7:15 a.m., R3 had a fall in her bedroom and was found crawling on her knees pushing her walker down the hallway. Interventions included reminding R3 to use her walker, safety checks, staff to assist as needed, gripper socks, and a sign was placed on the walker to remind her to use it which seemed to work after a while; - September 6, 2025, at 4:50 a.m., resident had a fall in the bedroom on her way back to bed after using the bathroom. R3 was found sitting close to the bed and said she hit her head. Interventions were done with the fall on September 5, 2025, as one; - September 12, 2025, at 5:10 p.m., R3 fell in the living room trying to sit in the recliner and said her head hurt a little. Interventions included ordering	01620		

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01620	Continued From page 23 a bed alarm, family brought in more gripper socks, encouraged resident to use the gripper socks, and reminding to use her walker. R3 would take her gripper socks off; - R3's Fall Risk Assessment dated September 15, 2025, noted a score of 8, indicating a risk for falls. It noted "Resident is at risk for falls as indicated by fall risk assessment score related to age, diagnoses, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed. PT will be initiated PRN. Safety checks. Service to remind resident to use walker and have walker placed by resident. Staff to assist as needed with ambulation or transfers. Resident encouraged to use gripper socks. Bed alarm."; - September 18, 2025, at 7:08 a.m., R3 had a fall in her bedroom and was found on her back with her head next to the dresser. She sustained a hematoma to the right side of her head and a scratch on her nose. R3 said she did not know what happened. Interventions included adding the bed alarm, looking at the environment to be free of clutter, and a pressure alarm. R3 was admitted to hospice the day before; -September 19, 2025, at 7:40 a.m., R3 fell in the bathroom and was found between the bathroom and bedroom. R3 did not remember what happened. She hit her head and was lethargic. Interventions were completed with the fall from September 18, 2025; and - September 22, 2025, at 9:28 a.m., R3 fell in the bathroom and was found sitting on the floor next to her bed. Interventions included increased services to morning cares, dressing, grooming, having walker near resident, transfer and toileting was added. R3 was receiving assistance with toileting, but it was changed to a toileting program every two hours after this fall;	01620		

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RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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 24 - R3's Assessment dated September 25, 2025, noted R3 was unable to ambulate and was on hospice end of life care. Under the fall risk summary noted a score of 9. It noted "Resident is at risk for falls as indicated by fall risk assessment score related to age, diagnoses, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed. PT will be initiated PRN. Safety checks. Service to remind resident to use walker and have walker placed by resident. Staff to assist as needed with ambulation or transfers. Resident encouraged to use gripper socks. Bed alarm." On February 11, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-A reviewed the incidents with the surveyor and the interventions noted above were from the interview at this time. The licensee's Fall Prevention & Management policy dated September 10, 2025, noted the registered nurse would evaluate fall data to measure and analyze falls and review potential factors and follow-up actions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Riverside Assisted Living
812 Centre Street East
Royalton, MN 56373
Morisson County
Parcel:

Phone:

License Info

License: HFID 30537

Risk:
License:
Expires on:
CFPM: JONELLE L LANGER
CFPM #: 117540; Exp: 6/23/2026

Inspection Info

Report Number: F1037261051
Inspection Type: Full - Single
Date: 2/9/2026 Time: 12:00:52 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: TEST KITS FOR CHLORINE AND QUATERNARY AMMONIUM WERE SCHEDULED TO ARRIVE 2/10/26. ENSURE A TEST KIT IS AVAILABLE FOR EMPLOYEE USE OF MEASURING SANITIZING SOLUTIONS AT ALL TIMES OF OPERATION.

Comply By: 2/16/2026 Originally Issued On: 2/9/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-602.11E *Priority Level: Priority 3 CFP#: 16*

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT: FOOD EMPLOYEE DIDN'T KNOW THE FREQUENCY THAT THE WATER PITCHERS WERE CLEANED. CLEAN THE WATER PITCHERS AT A FREQUENCY TO PRECLUDE ACCUMULATION OF SOIL OR MOLD. SUGGESTED ADDING IT TO THEIR DAILY CHECKLIST.

Comply By: 2/9/2026 Originally Issued On: 2/9/2026

Food & Beverage General Comment

DISCUSSED MENU, HIGH RISK FOODS, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, COOLING, REHEATING, AND ORDERS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1037261051 from 2/9/2026

TAYLOR-JO HASERT

Michelle Hovanes,
Public Health Sanitarian 2

320-223-7307
michelle.hovanes@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Riverside Assisted Living
Royalton
County/Group: Morisson County

Inspection Info

Report Number: F1037261051
Inspection Type: Full
Date: 2/9/2026
Time: 12:00:52 PM

Food Temperature: Product/Item/Unit: MASHED POTATOES**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN IN RICE**; Temperature Process:** Ambient Air
Location: at 135 Degrees F.
Comment: AT ROOM TEMPERATURE FROM LUNCH SERVICE AND BEING TRANSFERRED TO CONTAINER FOR COOLING WHILE ONSITE.
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Riverside Assisted Living
Royalton
County/Group: Morisson County

Inspection Info

Report Number: F1037261051
Inspection Type: Full
Date: 2/9/2026
Time: 12:00:52 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 173 Degrees F.
Comment:
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F1037261051

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	1	Date: 2/9/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:00:52 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Riverside Assisted Living	812 Centre Street East	Royalton, MN	56373	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30537		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		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		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	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		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Michele L Thomas

Follow-up: Follow-up Date:

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30537016	**Date:** 2/10/2026
Facility Name: Riverside Assisted Living	
Facility Address: 812 CENTRE STREET EAST ROYALTON, MN 56373	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: The emergency exit doors 3 (S.E.) and 4 (N.E.), did not have the snow removed so that there was a clear pathway leading to a public way.

3. Water-based automatic sprinkler systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: The annual fire sprinkler system(s) report listed deficiencies with the systems. One deficiency was flushing the pipes and the other one was for checking the gauges.

4. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: *There was evidence of past smoking in resident room # 7. Cigarette burns and ashes were observed on the windowsill.*

5. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable

appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: There was a full-size refrigerator in the basement that was plugged into an extension cord. The extension cord extended through the ceiling rafters, where it was plugged into the wall outlet on the opposite side of the basement.

6. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: There was a carbon monoxide alarm with a local alarm provided in the furnace and hot water heater room, but there were no carbon monoxide alarms installed within 10 feet of the sleeping rooms.

☒ **TAG IDENTIFICATION: 0800**

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

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments: Stained ceiling tile was found in the manager's office due to a previous leak. Tobacco was lying on the floor, nightstands, and dressers in rooms 7 and 12. Resident bedroom 12 had stained and torn carpet.

☒ **TAG IDENTIFICATION: 0810**

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

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site 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 FSEP inaccurately referenced smoke compartments and fire doors, but this facility was not equipped with those features.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP inaccurately referenced smoke compartment and fire doors but this facility was not equipped with those features.

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

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with no unique or unusual needs for movement or evacuation for residents to take in the event of a fire or similar emergency.