



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2026

Licensee
Arbor Garden Place
535 Canyon Drive Northwest
Eyota, MN 55934

RE: Project Number(s) SL30217017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER ARBOR GARDEN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 535 CANYON DRIVE NW EYOTA, MN 55934		
(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: SL30217017-0 On August 17, 2026, through August 20, 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 39 resident(s); 38 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 August 18, 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	0 480			
0 510 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of six unlicensed personnel (ULP-E, ULP-H) during personal cares. 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).	0 510			

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0 510	Continued From page 4 The findings include: ULP-E On August 17, 2026, at 1:10 p.m., the surveyor observed ULP-E knock and enter R4's apartment. ULP-E donned clean gloves, obtained a urinal and emptied the urine from R4's urinary catheter leg bag into the urinal and cleansed the port of the catheter bag with an alcohol wipe. ULP-E rinsed the urinal with vinegar and water and removed her gloves, said goodbye and left R4's apartment. ULP-E then went to R5's apartment, knocked and entered the apartment. The surveyor observed ULP-E assist R5 transfer from his recliner to his wheelchair, transported him to his bathroom and provided suprapubic catheter site care. ULP-E donned gloves removed the old split gauze, washed the insertion site, and catheter tubing at the site. ULP-E removed her gloves and donned clean gloves, redressed with a clean split gauze and taped in place. ULP-E then emptied R5's catheter leg bag, removed her gloves, pushed R5 in his wheelchair to the living room area and assisted R5 to transfer back to his recliner. ULP-E opened the door and left R5's apartment. ULP-E documented the task on her tablet and went to tend to other duties. ULP-E failed to wash/sanitize her hands following glove use with catheter site care and urine bag management. ULP-H On August 18, 2026, at 6:45 a.m., the surveyor observed ULP-H finishing assisting R8 with compression stockings, donned gloves and assisted R8 with an incontinence brief change, removed her gloves and assisted R8 to the dining room area. (no handwashing/sanitizing) ULP-H	0 510			

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0 510	Continued From page 5 then went directly to R9's room and assisted R9 with dressing. ULP-H then assisted R9 to the dining room and went to the medication cart. (no handwashing/sanitizing) and set up R8's medications. ULP-donned a clean pair of gloves and administered a topical pain patch and a topical gel to R8's back. ULP-H removed and discarded her gloves and administered R8's oral medications. ULP-H then documented the medication administration on the tablet at the medication cart. (no handwashing/sanitizing). At 8:10 a.m., ULP-H was observed to serve breakfast (no handwashing prior to handling trays). ULP-H then went to the medication cart and began setting up and crushed R10's medications, mixed them with orange juice and gave the medications/juice to R10 at the breakfast table. ULP-H returned to the medication cart, opened a drawer to return the pill crusher and briefly pulled out a bottle of hand sanitizer, stating, "I am terrible with hand sanitizer, I admit it." She sanitized her hands and returned the bottle to the drawer. She stated the sanitizer was kept in the drawer due to being in the memory care unit and not wanting residents to get to it. At 8:35 a.m., ULP-H began setting up R11's medications but needed to pause and redirect another resident who was wandering and upset. ULP-H put the medications in the medication cart drawer, locked the medication cart and brought that resident to another area and attempted to engage her in an activity. ULP-H came back to the medication cart, opened the cart and finished setting up R11's medications. ULP-H went to R11's room, donned a clean set of gloves and administered a topical medicine with a Q-Tip to various areas of R11's upper extremities. ULP-H removed her gloves, administered R11's oral medications and took R11's blood pressure. ULP-H left R11's room, went to the kitchen/dining	0 510			

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0 510	Continued From page 6 area, removed breakfast dishes from the table and placed them on the kitchen cart. ULP-H then went to the medication cart and finished her documentation of medication administration. ULP-H again redirected an upset resident and returned to the medication cart and set up and administered R12's medications. The surveyor observed ULP-H between 6:45 a.m. and 9:20 a.m., ULP-H sanitized her hands one time between contact with several residents and touching multiple surfaces. At 10:15 a.m., the surveyor observed ULP-H and ULP-J assist R6 with cares and repositioning. Both ULP-H and ULP-J donned clean gloves, turned R6 to her side and removed a soiled incontinence brief. ULP-H used wipes to cleanse R6's soiled bottom, discarded the soiled brief and wipes in the trash and placed a clean incontinence brief under her. With the same gloves, ULP-H assisted with turning R6 to the other side, scooted her up in bed, placed a pillow between R6's legs and repositioned a pillow under her head. ULP-H lowered R6's bed via an electric hand control and then removed her gloves. ULP-H then returned to the medication cart to document the cares performed. (hands not washed/sanitized) At 10:40 a.m., the surveyor discussed with ULP-H, the observed lack of handwashing/sanitizing with R6's personal cares/incontinence brief change and touching bedding and pillows with soiled gloves. ULP-H stated it made sense to remove soiled gloves immediately after working with soiled items and before touching other items (pillows). She stated she forgets to wash/sanitize hands and needs to work on it. She further stated she planned to get a small bottle of hand sanitizer to keep in her pocket to help remember to use between	0 510			

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0 510	Continued From page 7 residents. ULP-H failed to remove her gloves immediately following working with soiled briefs and before touching bedding, pillows and a bed control. Additionally, ULP-H failed to wash/sanitize hands between resident contact and following cares on multiple occasions throughout the morning. On August 18, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated she expected staff to remove soiled gloves immediately after working with soiled briefs, sanitize hands before touching other surfaces, and expected staff to always sanitize hands between resident contact. The licensee's Procedure for Using Gloves policy dated June 19, 2023, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container. Rewash hands. The licensee's Standard Precautions for Infection Control policy dated June 19, 2023, indicated hand washing is crucial. Staff will wash hands after touching blood, body fluids, feces, or contaminated items, before putting on gloves, immediately after gloves or gowns are removed and as necessary between tasks and procedure on the same resident to prevent cross-contamination of different body sites, and between all patient contacts. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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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 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 documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-H). 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 client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 660			

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0 660	Continued From page 9 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H's employee record indicated a hire date of October 10, 2025, to provide direct care services to the licensee's residents. On August 18, 2026, at 7:38 a.m., the surveyor observed ULP-H set up and administer R8's morning oral and topical medications. ULP-H's employee file included documentation of a completed health history and symptom screening dated October 15, 2025, and evidence she completed "step two" of a two step TST on October 15, 2025, with a negative result on October 17, 2025; however, ULP-H's record lacked evidence a first step TST was completed. On August 20, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated ULP-H's employee file appeared only to have evidence of the second TST, and was not certain why the file lacked the first TST. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.	0 660			

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0 660	Continued From page 10 The licensee's TB Prevention and Control policy dated June 19, 2023, indicated upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or share space with resident until TB testing and screening is completed and a negative TB test is provided. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 775 SS=I	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, record review, and interview, 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	0 775			

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NAME OF PROVIDER OR SUPPLIER ARBOR GARDEN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 535 CANYON DRIVE NW EYOTA, MN 55934		
(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
0 775	Continued From page 11 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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 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	0 780			

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0 780	Continued From page 12 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 13 (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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			

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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. This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 810			

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0 810	Continued From page 15 interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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.	0 900			

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0 900	Continued From page 16 (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 existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to sign one of one resident's contract (R4), documenting agreement between the resident and the facility, as required. 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:	0 900			

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0 900	Continued From page 17 R4 started receiving services from the licensee on February 7, 2025, with diagnoses including history of stroke with right sided hemiparesis (weakness/paralysis), heart failure and type 2 diabetes. R4's Service Plan dated January 31, 2026, included the services of medication management, blood sugar monitoring, compression stockings, suprapubic catheter (urinary catheter place through the abdominal wall into the bladder) site care and urine bag management, stand by assistance with transfers/ambulation, and bathing. On August 17, 2026, at 1:10 p.m., the surveyor observed unlicensed personnel (ULP)-E knock and enter R4's apartment. ULP-E donned clean gloves, obtained a urinal and emptied the urine from R4's urinary catheter leg bag into the urinal and cleansed the port of the catheter bag with an alcohol wipe. ULP-E rinsed the urinal with vinegar and water and removed her gloves. R4's record included the licensee's assisted living with dementia care contract and was signed by R4 and R4's resident representative on February 7, 2025; however, the licensee failed to sign the contract. On August 20, 2026, at 12:06 p.m., licensed assisted living director (LALD)-A stated R4's contract had been managed by the LALD before her and appeared to not have signed the contract as the facility representative. She further stated she looked through other paper files and could not find evidence of another contract for R4 that included a facility representative signature. No further information was provided.	0 900			

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0 900	Continued From page 18	0 900			
01290 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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 observation, interview, and record review, the licensee failed to ensure one of 36 employees (director of maintenance (DOM)-G) was affiliated with the assisted living license as required. This had the potential to affect all residents residing 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01290			

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01290	Continued From page 19 or has the potential to affect a large portion or all the residents). The findings include: DOM-G had a hire date of March 10, 2025, and shared his role as Director of Maintenance with a sister facility. On August 17, 2026, from 11:00 a.m. through 1:00 p.m., the surveyor observed DOM-G independently working in various locations of the facility and in an office area. On August 17, 2026, at 2:30 p.m., the surveyor reviewed the licensee's NETStudy roster and the licensee's employee roster and noted DOM-G was not listed on either roster. On August 17, 2026, at 3:42 p.m., licensed assisted living director (LALD)-A stated DOM-G worked between this facility and a sister facility (with a cleared background study) and had not noted the licensee's facility roster did not include DOM-G. She further stated she did not have access to NETStudy but had the corporate office affiliate him with the licensee following the surveyor's inquiry. LALD-A provided the surveyor with an updated NETStudy roster that included DOM-G with an affiliation date of August 17, 2026 (date of survey). The licensee's Background Checks policy dated June 2024, indicated [licensee name] will conduct background checks on applicants and other individuals as required by federal, state, and local law. Human Resources will make all reasonable efforts to ensure that background checks are complete prior to the first day of team member orientation.	01290			

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01290	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first 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 one of two unlicensed personnel (ULP-H) performing delegated tasks was	01440			

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01440	Continued From page 21 provided by the registered nurse (RN) within 30 calendar days after the date on which the individuals began working for 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 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: ULP-H's employee record indicated a hire date of October 10, 2025, to provide direct care services to the licensee's residents. On August 18, 2026, at 7:38 a.m., the surveyor observed ULP-H set up and administer R8's morning oral and topical medications. ULP-H's employee file included a document named Minnesota Assisted Living: Nurse Supervisory Visit Form dated May 1, 2026, and was signed by licensee's licensed practical nurse (LPN)-C. On August 20, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated ULP-H's employee file included a 30-day RN supervision document that was completed by the licensee's LPN. CNS-B stated she understood an LPN could not perform supervisory duties per Minnesota Board of Nursing scope of practice and stated she (as the RN) had not completed a 30-day RN supervision evaluation for ULP-H.	01440			

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01440	Continued From page 22 The licensee's Supervision of Unlicensed personnel policy dated June 2026, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins for our facility and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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;	01470			

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01470	Continued From page 23 (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 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 two employees (unlicensed personnel (ULP)-E,	01470			

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01470	Continued From page 24 ULP-H) 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 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-E ULP-E had a hire date of May 25, 2025, to provide direct support services to the licensee's residents. On August 17, 2026, at 1:10 p.m., the surveyor observed ULP-E empty R4's urinary catheter leg bag and clean the urinal with vinegar/water mixture. ULP-H ULP-H had a hire date of October 10, 2025, to provide direct support services to the licensee's residents. On August 18, 2026, at 7:38 a.m., the surveyor observed ULP-H set up and administer R8's morning oral and topical medications ULP-E and ULP-H's record lacked evidence they received orientation to assisted living facility to include the following required content: - overview of Assisted Living statutes; - handling resident complaints; and	01470			

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01470	Continued From page 25 - consumer advocacy services Additionally, ULP-H's training record lacked evidence she completed: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On August 20, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A stated she was unable to find evidence of the above listed training in the assigned Relias training module set or in the licensee's orientation power point, and would likely affect all staff. She further stated the licensee had moved to a new education platform in August 2026, and she would ensure this content was included for all new staff moving forward and would assign the training to current staff. LALD-A further stated ULP-H had been assigned the person-centered planning training; however, ULP-H had been hard to track down form training and likely had not completed it. The surveyor requested a policy for the content of employee orientation; however, the policy was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of	01540			

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01540	Continued From page 26 the employment start date. Until this initial training is complete, the 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 two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-H) received the required amount of dementia, mental illness, and de-escalation 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 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:	01540			

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01540	Continued From page 27 The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license. ULP-H's employee record indicated a hire date of October 10, 2025, to provide direct care services to the licensee's residents. On August 18, 2026, at 7:38 a.m., the surveyor observed ULP-H set up and administer R8's morning oral and topical medications. ULP-H's employee record contained evidence of completing four hours of dementia training and 1.25 hours of mental illness and de-escalation training within 80 hours of work. ULP-H failed to complete the required eight hours of dementia training and the required two hours of mental illness training. On August 20, 2026, at 10:45 a.m., licensed assisted living director (LALD)-A stated ULP-H was behind on her assigned training and had worked greater than 80 hours since her hire date. The licensee's Dementia Training policy dated April 2025, indicated direct care employees of an Assisted Living with Dementia Care licensed setting would complete a minimum of eight hours initial training on dementia care topics. The initial training will be completed within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			

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01620	Continued From page 28	01620			
01620 SS=F	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 29 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment 14 days after admission for two of three residents (R5, R6), an assessment for a change in condition for one of three residents (R6) and a reassessment not to exceed 90 days for three of three residents (R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 17, 2026, at 11:15 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated the RN completed RN assessments at the time of admission, 14 days	01620			

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01620	Continued From page 30 following admission and every 90 days. She further stated she recognized a resident's admission to hospice care was a change in condition and triggered a Change in Condition RN assessment. R4 R4 started receiving services from the licensee on February 7, 2025, with diagnoses including history of stroke with right sided hemiparesis (weakness/paralysis), heart failure and type 2 diabetes. R4's Service Plan dated January 31, 2026, included the services of medication management, blood sugar monitoring, compression stockings, suprapubic catheter (urinary catheter place through the abdominal wall into the bladder) site care and urine bag management, stand-by assistance with transfers/ambulation, and bathing. On August 17, 2026, at 1:10 p.m., the surveyor observed unlicensed personnel (ULP)-E knock and enter R4's apartment. ULP-E donned clean gloves, obtained a urinal and emptied the urine from R4's urinary catheter leg bag into the urinal and cleansed the port of the catheter bag with an alcohol wipe. ULP-E rinsed the urinal with vinegar and water and removed her gloves. R4's record included the following RN assessments: - October 22, 2025, indicated as a 90-day reassessment; - December 26, 2025, indicated as a 90-day reassessment; and - April 2, 2026, indicated as a 90-day reassessment (completed at 97 days)	01620			

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01620	Continued From page 31 No RN assessment has been completed since April 2, 2026, which would have been due July 1, 2026, (as 90-day reassessment). The licensee failed to ensure the RN completed a reassessment not to exceed 90 days following the assessments dated December 26, 2025, and April 2, 2026. R5 R5 started receiving services from the licensee on April 9, 2026, with diagnoses including multiple sclerosis (an autoimmune disease affecting the central nervous system) and neurogenic bladder with presence of a suprapubic catheter (urinary catheter place through the abdominal wall into the bladder). R5's unsigned Service Plan dated April 27, 2026, included the services of medication management/administration, assistance with suprapubic catheter site care and urinary bag management, stand-by assistance with transfers, and bathing reminders. On August 17, 2026, at 1:20 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R5 transfer from his recliner to his wheelchair, transported to his bathroom and provided suprapubic catheter site care. ULP-E donned gloves removed the old split gauze, washed the insertion site, and catheter tubing at the site. ULP-E removed her gloves and donned clean gloves, redressed with a clean split gauze and taped in place. ULP-E then emptied R5's catheter leg bag, removed her gloves, pushed R5 in his wheelchair to the living room area and assisted R5 to transfer back to his recliner. R5's record included the following RN	01620			

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01620	Continued From page 32 assessments: - April 8, 2026, preadmission RN assessment; and - May 1, 2026, 14-day reassessment (completed 22 days after admission) No RN assessment has been completed since May 1, 2026, which would have been due by July 30, 2026. The licensee failed to ensure the RN completed a reassessment at 14 days following R5's admission date and further failed to complete a reassessment not to exceed 90 days following the RN assessment completed on May 1, 2026. R6 R6 started receiving services from the licensee on October 17, 2025, with diagnoses including Alzheimer's disease. R6's Service Plan dated August 11, 2026, included the services of medication management/administration, hospice services, assistance of two for incontinence care, turning/repositioning every two hours, bathing and dressing and assistance of one for feeding. On August 18, 2026, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-J assist R6 with changing her incontinence brief and repositioning in her bed. ULP-H stated R6 was on hospice and required assistance with all cares, medication administration and feeding. She further stated R6 had been bedbound for the past week and required repositioning every two hours. R6's progress note dated January 29, 2026, indicated R6 was admitted to [hospice name] late	01620			

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01620	Continued From page 33 on January 29, 2026. R6's record included the following RN assessments: - October 16, 2025, indicated as a pre-admission assessment; - January 16, 2026, indicated as 90-day reassessment; - March 26, 2026, indicated a change in condition (hospice admission-done 56 days after hospice started); and - August 6, 2026, indicated a 90-day reassessment (was due June 24, 2026) The licensee failed to ensure the RN completed a 14-day reassessment after R6's date of admission. Furthermore, the licensee failed to ensure the RN completed a timely RN assessment for a change in condition following R6's hospice admission (56 days after hospice started) and failed to complete a reassessment not to exceed 90 days following March 26, 2026, assessment. On August 20, 2026, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated she recognized she was and continued to be behind on many of the residents' assessments and was working through her list to get caught up and complete them. The licensee's Resident's Initial and Ongoing Assessments policy dated June 2026, indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90 days	01620			

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01620	Continued From page 34 d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The 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 the service plan included a signature or other authentication by the resident and the facility to document	01640			

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01640	Continued From page 35 agreement on the services provided for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R5 started receiving services from the licensee on April 9, 2026, with diagnoses including multiple sclerosis (an autoimmune disease affecting the central nervous system) and neurogenic bladder with presence of a suprapubic catheter (urinary catheter place through the abdominal wall into the bladder). R5's unsigned Service Plan dated April 27, 2026, included the services of medication management/administration, assistance with suprapubic catheter site care and urinary bag management, standby assistance with transfers, and bathing reminders. On August 17, 2026, at 1:20 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R5 transfer from his recliner to his wheelchair, transported to his bathroom and provided suprapubic catheter site care. ULP-E donned gloves removed the old split gauze, washed the insertion site, and catheter tubing at the site. ULP-E removed her gloves and donned clean gloves, redressed with a clean split gauze and taped in place. ULP-E then emptied R5's catheter	01640			

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01640	Continued From page 36 leg bag, removed her gloves, pushed R5 in his wheelchair to the living room area and assisted R5 to transfer back to his recliner. R5's record included a Service Plan dated April 27, 2026, that included an electronic signature by the licensee's registered nurse (RN); however, the Service Plan lacked a signature by R5 or R5's representative. On August 20, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated she had revised/updated R5's Service Plan on April 27, 2026, to reflect changes with R5's suprapubic catheter management; however, she did not have R5 or R5's representative sign the updated service plan. The licensee's Service Plan policy dated December 28, 2023, indicated: 1. Within 14 days after the date that services are first provided to a resident, [licensee's name] will finalize a written service plan. 2. The service plan and any revisions shall include a signature or other authentication by [licensee's name] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890			

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01890	Continued From page 37 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor expired medications for one of 38 residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 18, 2026, at 8:50 a.m., the surveyor reviewed the licensee's memory care medication cart with unlicensed personnel (ULP)-E. ULP-E observed and confirmed the following findings: -R6 haloperidol 1 milligram (mg) compounded solutab (used with hospice patients with swallowing difficulty) given for agitation/nausea. The label indicated an expiration date of July 15, 2026. The bubble pack indicated the medication was last used on July 13, 2026. The licensee failed to ensure all medications had not exceeded their expiration date. On August 20, 2026, at 11:00 a.m., CNS-B stated the expired medications should have been removed from the medication cart.	01890			

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01890	Continued From page 38 The licensee's Assisted Living Storage of Medications-MN policy dated June 2026, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original container bearing the original prescription label with legible information stating the prescription number, name of the drug, strength and quantity of drug, expiration date of time-dated drug, directions for used, resident's name, prescriber's name, date of issue and name and address of the licensed pharmacy. The policy indicated that medications will be handled and stored by acceptable standards. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER ARBOR GARDEN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 CANYON DRIVE NW EYOTA, MN 55934			
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02040	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER ARBOR GARDEN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 535 CANYON DRIVE NW EYOTA, MN 55934		
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02110	Continued From page 40 person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in assisted living facilities with dementia care were created and provided to each resident and/or the resident's legal and designated representative at the time of move-in for three residents (R4, R5, R6). This practice resulted in a level two violation (a	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
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02110	Continued From page 41 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: The licensee was licensed as an Assisted Living with Dementia Care facility on April 28, 2026. R4, R5, and R6's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy should be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/20/2026
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02110	Continued From page 42 only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On August 20, 2026, at 2:00 p.m., licensed assisted living director (LALD)-A stated she was not aware of the required dementia related policies and that they were not provided to the licensee's residents at the time of admission. LALD-A stated she had only been providing a copy of the licensee's dementia training program as was posted in the facility's entrance. LALD-A further stated the corporate office (management company) was developing the dementia care policies and were waiting for approval and then would be distributed to the residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240			

Minnesota Department of Health

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02240	Continued From page 43 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's complaint procedure was provided, and a written acknowledgement was received for two of three residents (R4, R5). Furthermore, the licensee failed to ensure the current Bill of Rights was provided, and a written acknowledgement was	02240			

Minnesota Department of Health

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02240	Continued From page 44 received for one of three residents (R5). This practice resulted in a level one violation (a violation that has not 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 the residents). The findings include: R4 R4 started receiving services from the licensee on February 7, 2025, with diagnoses including history of stroke with right sided hemiparesis (weakness/paralysis), heart failure and type 2 diabetes. R4's Service Plan dated January 31, 2026, included the services of medication management, blood sugar monitoring, compression stockings, suprapubic catheter (urinary catheter place through the abdominal wall into the bladder) site care and urine bag management, stand-by assistance with transfers/ambulation, and bathing. R5 R5 started receiving services from the licensee on April 9, 2026, with diagnoses including multiple sclerosis (an autoimmune disease affecting the central nervous system) and neurogenic bladder with presence of a suprapubic catheter (urinary catheter place through the abdominal wall into the bladder) R5's unsigned Service Plan dated April 27, 2026, included the services of medication	02240			

Minnesota Department of Health

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02240	Continued From page 45 management/administration, assistance with suprapubic catheter site care and urinary bag management, standby assistance with transfers, and bathing reminders. R4 and R5's records lacked written acknowledgement they or their resident representative had received the licensee's complaint procedure. R5's record lacked written acknowledgement he or his resident representative had received the current Bill of Rights. On August 20, 2026, at 11:00 a.m., licensed assisted living director (LALD)-A stated she was unable to find verification of the above listed forms and was developing an updated signature page to include verification the residents/resident representative had received the complaint procedure (found in the resident handbook), and the current Bill of Rights. LALD-A further stated the licensee had an inconsistent process to ensure all residents/resident representatives received written acknowledgement of the above listed forms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

ARBOR GARDEN PLACE
535 CANYON DRIVE NW
Eyota, MN 55934
Olmsted County
Parcel:

Phone: 507-545-3999
dbaumann-fern@arbogardenplace.com

License Info

License: HFID 30217
Darci Baumann-Fern
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1038261135
Inspection Type: Full - Single
Date: 8/18/2026 Time: 8:17:28 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT:

THERE IS A SLOW COOKER THAT IS AN ITEM THAT IS NOT APPROVED FOR USE

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

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT:

NO DEVICE IS ON SITE

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

New Order: 4-500 Equipment Maintenance and Operation

4-501.12 Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

COMMENT:

CUTTING BOARDS ARE SCORED

Comply By: 8/25/2026 Originally Issued On: 8/18/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT:

NEITHER DISHWASHER CAN GET TO THE CORRECT TEMPERATURE

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

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT:

HANDWASHING SINK IN SERVING AREA HAS A DISH IN IT. THE SINK IS FOR HANDWASHING ONLY

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

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

I acknowledge receipt of the Rochester District Office inspection report number F1038261135 from 8/18/2026

Eric Hershey
Kitchen Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30217017-0	Date: August 17, 2026
Facility Name: Arbor Garden Place	
Facility Address: 535 Canyon Drive NW, Eyota, MN 55934	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; 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. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments:

- The labeled fire door outside the main kitchen was held open with a wedge.
- Door closing devices were disconnected from one hour labeled fire doors for the laundry room and pantry on the first floor.
- On the second floor, labeled fire doors did not positively latch for the trash room, salon, resident care office, and east wing storage room.
- The labeled fire door between the east and west wings on the second floor was held open with a device not tied into the building fire alarm system.
- The door closing device was disconnected from the one hour labeled fire door for the laundry room on the second floor.
- The door leading into the east wing on the first floor was missing. Director of maintenance (DOM)-G stated this fire door was removed to make it easier for residents to pass through this area.

Fire doors shall be maintained to contain fire and smoke in the event of an emergency.

3. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010..2]

Comments: There were two emergency exit doors leading to courtyards enclosed by fences with gates. The gate opening hardware was installed on the non-exit side (outside the fence) and was not accessible to the building occupants to open these gates from the exit side.

4. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: The vent was disconnected from the clothes dryer in the laundry room on the second floor and there was an accumulation of lint behind the clothes dryer, creating a fire hazard. Director of maintenance (DOM)-G reinstalled the vent during the tour and stated a more permanent repair would be completed to prevent this from happening again.

5. 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: Gas fired mechanical equipment was installed in the east wing of the building on the first floor. A single station carbon monoxide detector was installed on the wall in the mechanical room. A carbon monoxide detector integrated with the fire alarm system was not installed in this area of the building and carbon monoxide alarms were not installed within ten feet of all resident bedrooms.

6. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: A remote emergency door release keyed switch was installed in the mechanical room on the first floor. The switch was outside the locked dementia care unit and was not readily accessible during an emergency. There were no references to the remote release switch in the facility emergency evacuation plans. The emergency evacuation procedures need to identify the location of this switch and include instructions on the proper use of the release mechanism. Additionally, the remote release mechanism for the controlled egress doors should be located in an accessible, approved location.

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

Comments: The fire alarm system inspection report dated December 9, 2025, indicated the horn did not work in resident unit 102. Director of maintenance (DOM)-G stated this had not been repaired.

8. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: Three carbon monoxide detectors were installed in the building. The fire alarm system inspection report dated December 9, 2025, indicated one carbon monoxide detector was tested. Director of maintenance (DOM)-G stated they did not know why all carbon monoxide detectors were not tested as part of this annual inspection.

9. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Two extension cords were used in occupied resident unit 205 to supply power to personal electronics. One of these extension cords was plugged into a power strip.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Two (2) days

-
1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: When director of maintenance (DOM)-G tested the smoke alarms in occupied resident unit 209, these dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
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: The spa tub was broken in the dementia care unit. Director of maintenance stated the licensee was researching replacement tubs but had not ordered a new unit yet.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the last year, from the licensee. Record review of the provided documentation indicated employees completed FSEP training on August 12, 2026. Employee training on the FSEP had been completed at the required frequency of twice per year.

2. 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. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for resident fire safety and evacuation training completed in the last year, from the licensee. These training records were not provided when requested. Director of maintenance stated residents were trained when they moved in and sometimes participated in drills. Residents were not offered this training at the required frequency of at least once per year.

3. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for evacuation drills completed in the past year from the licensee. The provided fire drill reports for 2025 and 2026, indicated drills were completed in March and June of 2026 and in March and May of 2025. The evacuation drill frequency was not met.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: The licensee failed to complete a site specific safety risk assessment on and around the property. The provided undated safety risk assessment was a template from a third party.