Electronically Delivered

August 10, 2026

Licensee
Campus A/l
809 Forest Avenue
Northfield, MN 55057

RE: Project Number(s) SL30702017

Dear Licensee:

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

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:

1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30702	A. BUILDING: _____ B. WING _____	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS A/L	809 FOREST AVENUE NORTHFIELD, MN 55057

(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: SL30702017-0 On July 13, 2026, through July 15, 2026 the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on July 14, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 14, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2	0 630		

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0 630	Continued From page 4 R2 was admitted on June 12, 2026, with diagnoses that included congestive heart failure. On July 14, 2026, 9:23 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medication to R2. R2's service plan dated June 12, 2026, indicated R2 received services to include grooming, dressing, bathing, catheter care, toileting, mobility/ambulation, oxygen and medication administration. R2's IAPP Form dated June 24, 2026, indicated R2 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. R3 R3 was admitted on March 2, 2022, with diagnoses that included diabetes. On July 14, 2026, at 9:12 a.m., the surveyor observed ULP-C administer medications to R3. R3's service plan dated July 15, 2025, indicated R3 received services to include grooming, bathing, toileting, mobility/ambulation, transferring, medication administration and weekly diabetic testing. R3's IAPP Form dated June 16, 2026, indicated R3 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R3 was a vulnerable adult and was susceptible to abuse/neglect by	0 630		

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0 630	Continued From page 5 others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. On July 15, 2026, at 10:40 a.m., quality consultant (QC)-G reviewed R2 and R3's IAPP and stated their IAPP should have indicated they were at risk to be abused and included interventions to minimize abuse by others. The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated all residents are considered vulnerable adults and the staff would assess each resident for vulnerability, create and implement and individualized abuse prevent plan to prevent harm. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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.	0 660		

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0 660	Continued From page 6 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 13, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record contained a one-step TST dated June 4, 2024. ULP-D's employee record lacked evidence of a Two-step TST or other evidence of TB screening such as a blood test. On July 15, 2026, at 10:47 a.m., quality consultant (QC)-G stated ULP-D's employee	0 660		

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0 660	Continued From page 7 record lacked a two-step TST or blood test as required. The licensee's Tuberculosis Prevention and Control policy dated August 10, 2022, indicated TB screening and testing of all volunteers and employees would be completed upon hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. 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	0 700		

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0 700	Continued From page 8 or has the potential to affect a large portion or all of the residents). The findings include: On July 13, 2026, at 1:10 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare to administer medications to R9. ULP-D logged into the laptop and pulled up R9's record, prepared the medications and went to R9's room. ULP-E left R9's record open on the laptop screen which was visible to others. On July 13, 2026, at 1:20 p.m., the surveyor observed ULP-D prepare to administer medications to R10. ULP-D logged into the laptop and pulled up R10's record, prepared the medications and went to R10's room. ULP-E left R10's record open on the laptop screen which was visible to others. On July 14, 2026, at 6:47 a.m., the surveyor observed ULP-D walk away from the medication cart with the laptop on top of it. R2's record was open on the laptop screen which was visible to others. On July 15, 2026, at 10:35 a.m., quality consultant (QC)-G stated the laptop screen should be minimized or closed when staff were not using the computer. QC-G stated all staff were trained to keep resident records confidential and private from any unauthorized individuals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 730	Continued From page 9	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 10 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one discharged resident's record (R4) included a discharge summary with the required content according to MN Rules 4659.0120, Subp.9. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on November 10, 2025, and discharged on April 27, 2026. R4's discharge summary dated April 27, 2026, failed to include: - a summary of the resident's stay that includes allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that	0 730		

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0 730	Continued From page 11 includes the resident status, including baseline and current mental, behavioral, and functional status; - reconciliation of all predischarge medications with the resident's postdischarge prescribed and over-the-counter medications; and - postdischarge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The postdischarge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medication and nonmedical services the resident will need. On July 15, 2026, at 10:45 a.m., quality consultant (QC)-G stated R4's discharge summary did not include the required content as noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=E	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	0 775		

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CAMPUS A/L	809 FOREST AVENUE NORTHFIELD, MN 55057

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0 775	Continued From page 12 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 July 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 13 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to 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).	0 810		

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0 810	Continued From page 14 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of three employees (licensed assisted living	01290		

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01290	Continued From page 15 director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-I and ULP-J). This had the potential to affect all residents residing in the facility. This resulted in an immediate order on July 14, 2026. In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for two of two employees (ULP-K and ULP-L). This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 14, 2026, at 7:45 a.m., the surveyor reviewed the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster. The surveyor did not observe LALD/CNS-A, ULP-I, ULP-J, ULP-K and ULP-L on the licensee's roster for HFID 30702. At this time, the surveyor requested the quality director (QD)-G to review LALD/CNS-A, ULP-I, ULP-J, ULP-K and ULP-L's employee files for a background study clearance letter. LALD/CNS-A LALD/CNS-A was hired on June 18, 2014, to provide direct care and services to the facility's residents. LALD/CNS-A's employee record contained a background clearance letter dated June 23, 2022,	01290		

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01290	Continued From page 16 affiliated with the licensee. On July 14, 2026, at 8:45 a.m., a review of NETStudy showed that LALD/CNS-A had been affiliated with the assisted living facility HFID 30702 and two sister facilities (HFID 30490 and HFID 26754); however, was indicated as separated from the three facilities on July 9, 2025. ULP-I ULP-I was hired on July 8, 2021, to provide direct care and services to the facility's residents. ULP-I's employee record contained a background clearance letter dated June 23, 2021, affiliated with HFID 24063, which was a Home Care license that is no longer active. On July 14, 2026, at 8:38 a.m., a review of NETStudy showed that ULP-I was not affiliated with the HFID or any sister facilities. ULP-J ULP-J was hired on April 15, 2021, to provide direct care and services to the facility's residents. ULP-J's employee record contained a background clearance letter dated April 6, 2021, affiliated with a sister facility HFID 564. On July 14, 2026, at 8:40 a.m., a review of NETStudy showed that ULP-J had been affiliated with a sister facility HFID 564; however, was separated from the facility on June 23, 2022. ULP-K ULP-K was hired on July 17, 2025, to provide direct care and services to the facility's residents.	01290		

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01290	Continued From page 17 ULP-K's employee record contained a background clearance letter dated July 22, 2025, from a sister facility HFID 564. However, ULP-K was not affiliated with this facility's HFID 30702. ULP-L ULP-L was hired on June 22, 2026, to provide direct care and services to the facility's residents. ULP-L's employee record contained a background clearance letter dated May 17, 2023, from a sister facility HFID 564. However, the document was not affiliated with this facility's HFID 30702. On July 14, 2026, at 9:33 a.m., human resource director (HRD)-M stated when an employee accepted a position with the licensee the employee would receive paperwork to fill out for a background check. Once the employee completed the background paperwork and gave consent, the licensee submitted the request for a background study and then for the employee to be fingerprinted. HRD-M stated the recruiters should ensure this process has been completed prior to working on the floor. HRD-M stated his department was aware of some employees being affiliated with sister facilities and they were working on affiliating them with the current HFID. HRD-M and QD-G stated LALD/CNS-A, ULP-I, ULP-J, ULP-K and ULP-L's all worked independently providing direct care and services to the residents. HRD-M and QD-G stated LALD/CNS-A, ULP-I and ULP-J would be removed from the schedule until they completed the background process. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated a background study on an individual after a conditional offer of	01290		

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01290	Continued From page 18 engagement has been made and before an individual provides direct contact services to individuals receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at l.	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620		

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01620	Continued From page 19 (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 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01620		

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01620	Continued From page 20 The findings include: R1 was admitted on December 11, 2024, with diagnoses that included congestive heart failure. R1's service plan dated April 9, 2026, indicated R1 received services to include grooming, dressing, bathing, toileting assist, transfers, oxygen and medication administration. R1's ongoing nursing assessments dated January 6, 2026, April 8, 2026, and July 6, 2026, were reviewed. The April 8, 2026, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. On July 15, 2026, at 10:53 a.m., quality director (QD)-stated R1's April 8, 2026, assessment was completed late. The licensee's Nursing Assessment policy dated April 18, 2022, indicated the RN will reassess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. 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	01640		

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01640	Continued From page 21 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01640		

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01640	Continued From page 22 The findings include: R1 R1 was admitted on December 11, 2024, with diagnoses that included congestive heart failure. On July 14, 2026, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated April 9, 2026, indicated R1 received services to include grooming, dressing, bathing, toileting assist, transfers, oxygen and medication administration. R1's signed prescriber orders dated June 5, 2026, included the following: -torsemide 20 milligrams (mg); one tablet by mouth two times per day. Ensure blood pressure (BP) is not lower than 100/50 before administering. R1's medication administration record (MAR) dated July 2026, included the following: -torsemide 20 mg; one tablet by mouth two times per day. Ensure blood pressure (BP) is not lower than 100/50 before administering. R1's service plan did not include daily blood pressure checks. R3 R3 was admitted on March 2, 2022, with diagnoses that included diabetes. On July 14, 2026, at 9:12 a.m., the surveyor observed ULP-C administer medications to R3. R3's service plan dated July 15, 2025, indicated	01640		

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01640	Continued From page 23 R3 received services to include grooming, bathing, toileting, mobility/ambulation, transferring, medication administration and weekly diabetic testing. R3's MAR dated July 2026, did not include weekly diabetic testing. R3's monthly task log dated July 2026, did not include weekly diabetic testing. On July 15, 2026, at 10:42 a.m., quality consultant (QC)-G reviewed R1's service plan and stated it did not include daily blood pressure checks. QC-G reviewed R3's service plan and stated R3 no longer required weekly diabetic testing and that it should have been removed from R3's service plan. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse and as requested and/or agreed upon by the resident or the resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified	01730		

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01730	Continued From page 24 staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 13, 2026, at approximately 9:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to their residents at the facility. LALD/CNS-A stated medications were stored in medication carts and medications requiring refrigeration were stored in a locked refrigerator. R3 was admitted on March 2, 2022, with diagnoses that included diabetes. On July 14, 2026, at 9:12 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. R3's service plan dated July 15, 2025, indicated	01730		

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01730	Continued From page 26 R3 received services to include medication administration. R3's individualized medication management plan (found within the service plan) dated July 15, 2025, failed to include the required content: -a description of storage of medications based on the resident's needs and preferences On July 15, 2026, at 10:35 a.m., quality consultant (QC)-G stated R3's medications were stored in the medication cart. QC-G reviewed R3's medication management plan and stated R3's medication plan did not include the medication storage as noted above. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication, treatment and therapy management services that will be provided; b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; d. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; e. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 27 f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for two of	01750		

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01750	Continued From page 28 three residents (R1 and R3) for medication administration delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on December 11, 2024, with diagnoses that included congestive heart failure. R1's service plan dated April 9, 2026, indicated R1 received services to include medication administration. ANXIETY/AGITATION R1's medication administration record (MAR) dated July 2026, included the following PRN medications for anxiety/agitation: -haloperidol 0.5 milligrams (mg); one tablet by mouth every two hours as needed -lorazepam 0.5 mg; one tablet by mouth every two hours as needed CONSTIPATION R1's MAR dated July 2026, included the following PRN medications for constipation: -bisacodyl rectal suppository 10 mg; one suppository per rectum daily as needed -sennosides-docusate sodium 8.6-50 mg; one tablet by mouth daily as needed	01750		

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01750	Continued From page 29 PAIN R1's MAR dated July 2026, included the following PRN medications for pain: -acetaminophen rectal suppository 650 mg; one suppository rectally every six hours as needed -morphine solutab 5 mg; one tablet by mouth every two hours as needed The licensee did not provide instructions for the ULP to understand which PRN medication for anxiety/agitation, constipation, and pain should be used in which order. R3 R3 was admitted on March 2, 2022, with diagnoses that included diabetes. R3's service plan dated June 15, 2025, indicated R3 received services to include medication administration. R3's MAR dated July 2026, included the following PRN medications for constipation: -bisacodyl rectal suppository 10 mg; one suppository rectally once a day as needed -milk of magnesia 1200 mg/15 milliliter (ml); 30 ml by mouth as needed once a day -sennosides-docusate sodium 8.6-50 mg; two tablets by mouth once daily as needed The licensee did not provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. On July 15, 2026, at 10:37 a.m., quality consultant (QC)-G stated there were no written instructions regarding which PRN medications should be given in which order for R1 and R3's PRN medications as listed above.	01750		

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01750	Continued From page 30 The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the RN may delegate to ULP the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the ULP have satisfied the training requirements if: a. the RN has communicated information about the medication, treatment, or therapy to the resident and provided education if needed. Before performing the procedures, the RN has instructed the ULP in the proper methods to administer the medications, treatment and therapy and the ULP have demonstrated the ability to competently follow the procedures; The RN has developed written, specific instructions for each resident The RN has communicated with the ULP about the individual needs of the resident; and The RN has documented the ULP have been trained and have demonstrated competency to follow the procedures No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	01790		

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01790	Continued From page 31 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	01790		

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01790	Continued From page 32 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested one of two unlicensed personnel (ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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-D was hired on June 13, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked documentation	01790		

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01790	Continued From page 33 of training and competencies for providing medications to residents for unplanned time away when the RN was not available. On July 15, 2026, at 10:48 a.m., quality director (QD)-G stated training and competency testing on unplanned time away is part of the ULP orientation. However, ULP-D's employee record lacked evidence of training or competency testing for providing medications to residents for unplanned time away when the RN was not available. The licensee's Medications to be Given When Away From Home policy dated August 1, 2021, indicated for situations when there will be a short-term absence (not to exceed seven calendar days) that is not known in advance and a licensed nurse is not available to put the medications into a container for the resident or the resident's responsible person to take out of the building, the RN will train unlicensed staff to follow the policy when giving mediations to the resident or resident's responsible person to take out of the building. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 13, 2026, at 1:00 p.m., the surveyor observed an unattended and unlocked medication cart near the unlicensed personnel (ULP) station. Other residents were in the common area near the unlocked medication cart. On July 13, 2026, at 1:05 p.m., the surveyor observed ULP-D prepare to administer medications for R8. ULP-D logged into the laptop, pulled up R8's record, prepared the medications and went to R8's room. ULP-D left the medication cart unlocked and unattended. Other residents were in the common area near the unlocked medication cart. On July 13, 2026, at 1:20 p.m., the surveyor observed ULP-D prepare to administer medications to R10. ULP-D logged into the laptop, pulled up R10's record, prepared the medications and went to R10's room. ULP-D left	01880		

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01880	Continued From page 35 the medication cart unlocked and unattended. Other residents were in the common area near the unlocked medication cart. On July 14, 2026, at 7:09 a.m., the surveyor observed ULP-D prepare medications for R6. ULP-D logged into the laptop, pulled up R6's record, prepared the medications and went to R6's room. ULP-D left the medication unlocked and unattended. Other residents were in the common area near the unlocked medication cart. On July 14, 2026, at 9:20 a.m., the surveyor observed an unattended and unlocked medication cart near the ULP station. Other residents were in the common area near the unlocked medication cart. On July 15, 2026, at 10:33 a.m., quality consultant (QC)-G stated the medication cart should be locked when not in use and when staff are not present at the cart. The licensee's Storage of Medication policy dated January 6, 2021, indicated medications will be handled and stored per acceptable standards. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910		

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01910	Continued From page 36 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R4 was admitted to the licensee on November 10, 2025, and discharged on April 27, 2026. R4's medication administration record (MAR)	01910		

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01910	Continued From page 37 dated April 2026, included the following medications: -Acyclovir 400 milligrams (mg); one tablet by mouth two times per day (antiviral medication) -aripiprazole 10 mg; one tablet by mouth daily (depression) -Salmon Oil 1,000 mg; one capsule by mouth daily (supplement) -sertraline 100 mg; one and one-half tablet by mouth daily (depression) -Systane Complete eye drops 0.6%; instill one drop into eyes once daily (dry eyes) -Tab-A-Vite; one tablet by mouth daily (supplement) -trazodone 50 mg; one-half tablet by mouth once daily (sleep) -Vitamin B12; one tablet by mouth daily (supplement) -Vitamin D3 25 micrograms (mcg); one tablet by mouth daily (supplement) R4's discharge summary dated April 27, 2026, indicated R4's medications were destroyed by nursing staff. R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On July 15, 2026, at 10:46 a.m., quality consultant (QC)-G stated R4's record lacked a medication disposition record with the required content as listed above. QC-G stated the nurse had filled out a disposition of medications form but did not keep a copy for R4's record.	01910		

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01910	Continued From page 38 The licensee's Disposition or Disposal of Medications policy, undated, indicated: a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 39 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on December 11, 2024, with diagnoses that included congestive heart failure.	01940		

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	30702	A. BUILDING: _____ B. WING _____	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS A/L	809 FOREST AVENUE NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 R1's service plan dated April 9, 2026, indicated R1 received services to include grooming, dressing, bathing, toileting assist, transfers, oxygen and medication administration. R1's service plan did not include daily blood pressure checks. R1's signed prescriber orders dated June 5, 2026, included the following: -torsemide 20 milligrams (mg); one tablet by mouth two times per day. Ensure blood pressure (BP) is not lower than 100/50 before administering. -Oxygen Care: Administer 2 liters via nasal cannula for comfort. R1's medication administration record (MAR) dated July 2026, included the following: -torsemide 20 mg; one tablet by mouth two times per day. Ensure blood pressure (BP) is not lower than 100/50 before administering. -Oxygen Care: Administer 2 liters via nasal cannula for comfort. On July 14, 2026, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 which included torsemide 20 mg. ULP-D stated she had checked R1's blood pressure earlier in the morning and it was 148/93. R1's individualized treatment and therapy management plan (found within the service plan) dated April 9, 2026, did not include the following required content: -statement of the type of services that will be provided (daily blood pressure checks) -documentation of specific resident instructions relating to the treatments or therapy administration (oxygen management)	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 41 On July 15, 2026, at 10:40 a.m., quality consultant (QC)-G reviewed stated R1's treatment plan did not include daily blood pressure checks. QC-G stated R1's oxygen orders should have specific resident instructions on what the parameters for administering oxygen for comfort was. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: g. A statement describing the medication, treatment and therapy management services that will be provided; h. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; i. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; j. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; k. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel; l. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications,	01940		

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01940	Continued From page 42 treatments and therapy services are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01970		

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01970	Continued From page 43 The findings include: R1 was admitted on December 11, 2024, with diagnoses that included congestive heart failure. R1's service plan dated April 9, 2026, indicated R1 received services to include oxygen management. R1's medication administration record (MAR) dated July 2026, included the following: -Oxygen Care: Administer 2 liters via nasal cannula for comfort. R1's signed prescriber orders dated June 5, 2026, included oxygen 2 liters via nasal cannula for comfort; however, the order did not include specific parameters that required the administration of oxygen for R1's comfort. On July 15, 2026, at 10:46 a.m., quality consultant (QC)-G stated R1's prescriber orders for oxygen did not include specific directions on what as needed for comfort meant and would require staff to administer PRN oxygen to R1. QC-G stated she would contact R1's prescriber and obtain specific directions for oxygen use. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: g. A statement describing the medication, treatment and therapy management services that will be provided; h. A description of storage of medications based	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 44 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; i. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; j. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; k. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel; l. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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	02040		

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02040	Continued From page 45 assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, 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 July 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 46	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2026, at 1:25 p.m. during the engineer's survey visit, the engineer observed R2's room with four unsecured oxygen cylinder on the floor. On July 15, 2026, at 10:32 a.m., quality consultant (QC)-G stated all oxygen cylinders should be kept secured. QC-G stated she would re-educate the staff on proper oxygen storage. The licensee's Oxygen policy dated May 23,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 47 2025, indicated oxygen tanks must be secured with chains, racks or in stands. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

CAMPUS A/L
809 Forest Ave
Northfield, MN 55057
Rice County
Parcel:

Phone:

License Info

License: HFID 30702

Risk:
License:
Expires on:
CFPM: Jaculine Jean Ayers Howells
CFPM #: 59401; Exp: 6/18/2028

Inspection Info

Report Number: F7990261014
Inspection Type: Full - Single
Date: 7/14/2026 Time: 10:43:37 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

! **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: AT THE TIME OF INSPECTION THE HOT WATER SANITIZING DISH MACHINE WAS ONLY ACHIEVING 147.9 DEGREES F. USE OF THE 3 COMPARTMENT SINK FOR SANITIZING IN THE INTERIM WAS ADVISED.
Comply By: 7/14/2026 Originally Issued On: 7/14/2026

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, COOLING, HANDWASHING, SANITIZING PROCEDURES, NOROVIRUS PREVENTION AND BAREHAND CONTACT PREVENTION WITH READY TO EAT FOODS.

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 Mankato District Office inspection report number F7990261014 from 7/14/2026

Benjamin D. Ische

Rachel Studemann

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

CAMPUS A/L
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261014
Inspection Type: Full
Date: 7/14/2026
Time: 10:43:37 AM

Food Temperature: Product/Item/Unit: Traulsen Reach in Cooler Cheese**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

CAMPUS A/L
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261014
Inspection Type: Full
Date: 7/14/2026
Time: 10:43:37 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 148 Degrees F.
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

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

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30702017-0	**Date:** 7/13/2026
Facility Name: Campus A/I	
Facility Address: 809 Forest Avenue, Northfield, MN 55057	

☒ **TAG IDENTIFICATION: 0775**

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

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

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

   Comments: During the building tour, the surveyor asked environmental services director (ESD)-E if a remote button or switch was installed that would disengage the controlled egress locking system for the building and ESD-E stated no.

3. 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:
   <u>Forest Building</u>
   Labeled fire doors for resident rooms two and three were held open with wedging devices obstructing the self-closing function of the rated door. The licensee removed these wedging devices during the building tour.

4. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

Comments:
<u>Reflections Building</u>
A power strip was plugged into a multi-plug adapter in occupied resident room six.

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

   Comments: Sprinkler heads were obstructed by storage less than 18 inches below the deflector in the following locations:
   <u>Reflections Building</u>
   Inside the activities storage closet.
   <u>Forest Building</u>
   In room 101, boxes were stored on the top shelf of a storage unit. These boxes were removed by Environmental Services Director (ESD)-E during the building tour.
   Improper storage under a sprinkler head deflector would interfere with the spray pattern of water in the event of a fire.

6. 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 surveyor requested the most recent copy of the fire alarm system inspection report from environmental services director (ESD)-E. Record review of the provided inspection report, dated March 26, 2026, listed three smoke detectors as deficient in the Reflections Building. ESD-E provided documentation that these smoke detectors were scheduled for replacement on July 24, 2026.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments:
   - The licensee failed to maintain all parts of the fire safety and evacuation plan (FSEP) with accurate employee actions. The provided FSEP directed employees to utilize color coded emergency evacuation magnets on resident room door frames. The licensee stated these magnets were no

longer used and verified this part of the plan was not accurate. Additionally, the employee actions for fire inaccurately referenced an elevator.
- The FSEP had not been developed with site specific employee actions to take in the event of a fire relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronym.

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

   Comments: The provided fire safety and evacuation plan (FSEP) in the emergency binder failed to include evacuation procedures for the individualized unique needs of residents. The licensee stated these procedures were maintained electronically. These procedures would not be easily accessible to staff or emergency responders during a fire or similar emergency.

☒ **TAG IDENTIFICATION: 2040**

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

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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 safety risk assessment tool for the property and grounds, dated September 8, 2025, failed to include a mitigation strategy for each hazard identified.