Electronically Delivered

June 3, 2026

Licensee
Elysian Fields Red Wing
522 Riedell Court
Red Wing, MN 55066

RE: Project Number(s) SL41550015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 27, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41550	A. BUILDING: _____ B. WING _____	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN FIELDS RED WING	522 RIEDELL CT RED WING, MN 55066

(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: SL41550015-0 On May 26, 2026, through May 27, 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 15 residents; 15 receiving services under the Provisional 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		

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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 May 27, 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		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 4 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 complete fall assessments/follow up for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 19, 2025, with diagnoses that included dementia. R1's service plan dated May 12, 2026, indicated R1 received services to include grooming,	01620		

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01620	Continued From page 5 dressing, bathing, incontinence care, catheter care, toileting, compression stockings, escort/mobility assistance, repositioning, transfer assistance, safety checks, behavior management and medication administration. R1's fall reports and record review from December 1, 2025, through May 26, 2026, indicated the following falls and findings: -Fall incident report dated December 1, 2025, indicated R1 had a fall in her room. -Actions taken to prevent future falls: staff to keep resident in line of sight. If resident goes to her room, assist with toileting/getting her ready for bed. If resident agreeable, return her to the common area so she can be monitored. -Review of fall including a root cause analysis: resident has dementia and is being followed by hospice. Resident does not recall that she can no longer ambulate independently. She is impulsive and is unable to wait for staff to assist her. -Fall incident report dated December 5, 2025, indicated R1 had a fall in the dining room. -Actions taken to prevent future falls: try to keep client (resident) within visual range when out of her room in the common areas where others are. -Review of fall including a root cause analysis: client has dementia and is impulsive. She forgets she needs help to walk and transfer, which leads to falls. -Fall incident report dated December 11, 2025, indicated R1 had a fall in her bedroom. -Actions taken to prevent future falls: staff to keep resident in line of sight. If resident goes to her room, check for possible needs, such as toileting. Staff to monitor BMs (bowel	01620		

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01620	Continued From page 6 movements) and use appropriate PRNs (as needed medications). Resident does consume adequate amounts of water during the day always drinking from and having her straw cup filled. If trend in constipation noted-coordinate with hospice for plan of care. -Fall incident report dated January 5, 2026, indicated R1 had a fall in the living room. -Actions taken to prevent future falls: Resident is very impulsive and attempts to self-transfer. Multiple interventions are utilized: non-slip footwear, toileting and repositioning every two hours, bed/chair alarm, keeping resident in common area. Resident has dementia and "reminders" are ineffective. No pattern to time of falls. Resident has dementia and is being followed by hospice, falls are inevitable at this stage and family are aware of this. -Review of fall including a root cause analysis: resident has dementia and is being followed by hospice. Resident does not recall that she can no longer ambulate independently. She is impulsive and is unable to wait for staff to assist her. -Fall incident report dated February 8, 2026, indicated R1 had a fall in the common living room. -Actions taken to prevent future falls: continue to remind client (resident) to ask for assistance. Due to her dementia, family is aware not all falls can be prevented, but they have decreased. -Review of fall including a root cause analysis: looked at the video and client self transferred from commons area chair, went to walk away pushing her w/c (wheelchair) and the w/c rolled back on her and she fell onto her bottom and then back and laid down flat. She did not hit her head. Root cause is that the client forgets she cannot walk and self transfers.	01620		

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01620	Continued From page 7 -Fall incident report dated February 13, 2026, indicated R1 had a fall in the dining room. -Actions taken to prevent future falls: continue to remind client (resident) to ask for assistance. Due to her dementia family is aware not all falls can be prevented but they have decreased. -Review of fall including a root cause analysis: Client (resident) has dementia and is impulsive. She forgets she needs help to walk and transfer, which leads to falls. -Fall incident report dated February 14, 2026, indicated R1 had a fall in the common living room. -Actions taken to prevent future falls: keep reminding client (resident) she needs to ask for help to stand and that she does not walk well at this time. -Review of fall including a root cause analysis: client (resident) has dementia and is impulsive. She forgets she is older and needs help with transfers and cannot walk alone. -Fall incident report dated February 21, 2026, indicated R1 had a call in the common sitting room. -Actions taken to prevent future falls: keep items near client (resident) when she is sitting in her w/c so she does not feel she has to reach out and walk to get them. -Review of fall including a root cause analysis: client (resident) has dementia and is impulsive. She forgets she cannot walk without help and she either loses her balance or her w/c (wheel chair) slips and she falls. -Fall incident report dated February 22, 2026, indicated R1 had a fall in her room. -Actions taken to prevent future falls: family	01620		

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01620	Continued From page 8 has noticed when she goes to bed early, she is restless. They have asked that we try and not put her to bed until 8 or 8:30 p.m. Client (resident) used to have Trazodone for sleep but it was discontinued. Family requested it be restarted and hospice did as such. -Review of fall including a root cause analysis: client (resident) has dementia and is impulsive. She forgets she needs help to walk and transfer, which leads to falls. -Fall incident report dated February 26, 2026, indicated R1 had a fall in the living room. -Actions taken to prevent future falls: keep reminding client (resident) that she needs assistance to transfer due to her w/c status. -Review of fall including a root cause analysis: client (resident) has dementia and is very impulsive, when she wants to do something she does not wait she just does it without thinking. She thinks she is much younger than she is and she owns the building and she is running it. She forgets she cannot walk or transport herself due to weakness. -Fall incident report dated February 18, 2026, indicated R1 had a fall in the living room. -Actions taken to prevent future falls: remind client (resident) she needs help to stand. Ask for help when needed. -Review of fall including a root cause analysis: client (resident) has dementia and is impulsive. She forgets she needs help to walk and transfer, which leads to falls. Try and keep Kleenex close to her when she is sitting in living room as she tends to want Kleenexes. -Fall incident report dated March 6, 2026, indicated R1 had a fall in the living room. -Actions taken to prevent future falls: keep	01620		

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01620	Continued From page 9 reminding client (resident) that she needs help and to ask for it when she needs it. Keep things within her reach when she is sitting in w/c or in other chairs. -Review of fall including a root cause analysis: client (resident) wanted to walk and forgot she cannot without help. Has dementia. She gets restless after 2 p.m. -Fall incident reported March 9, 2026, indicated R1 had a fall in the living room. -Actions taken to prevent future falls: keep reminding client (resident) not to stand on her own. Due to her dementia and impulsivity falls are anticipated. -Review of fall including a root cause analysis: client (resident) is impulsive and has dementia. She forgets she can't walk, so she stands up and tries to walk and falls down. Many times she slides down from chair on to her bottom. No injuries sustained. -Fall incident report dated March 26, 2026, indicated R1 had a fall in the hallway outside of her bedroom. -Actions taken to prevent future falls: remind client (resident) to ask for assistance. -Review of fall including a root cause analysis: client (resident) wanted to get into her room. She stood up to open the door, lost her balance and fell. Client (resident) forgets she needs to ask for help. -Fall incident report dated April 8, 2026, indicated R1 had a fall in the dining room. -Actions taken to prevent future falls: educate staff to alert nursing if client (resident) starts to become agitated. Observe client (resident) for these signs of agitation that may lead to impulsiveness. Focus is on comfort over	01620		

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01620	Continued From page 10 restrictions. -Review of fall including a root cause analysis: client (resident) is on hospice with expected decline, generalized weakness and impulsiveness. -Fall incident report dated April 12, 2026, indicated R1 had a fall in the common area. -Actions taken to prevent future falls: keep reminding client (resident) not to stand on her own. Due to her dementia and impulsivity falls are anticipated. Let nursing know when she starts getting agitated. -Review of fall including a root cause analysis: client (resident) just gets up and tries to walk and usually ends up on the ground due to weakness in legs or w/c gets away from her and she falls. -Fall incident report dated April 15, 2026, indicated R1 had a fall in the dining room. -Actions taken to prevent future falls: remind staff to alert nursing if client (resident) starts to become agitated. Observe client (resident) for these signs of agitation that may lead to impulsiveness. Focus is on comfort over restrictions. -Fall incident report dated April 16, 2026, indicated R1 had a fall in the family room. -Actions taken to prevent future falls: keep reminding client (resident) that she needs help and to ask for it when she needs it. Keep things within her reach when she is sitting in w/c or in other chairs -Review of fall including a root cause analysis: Client (resident) is followed by hospice. She has dementia and is very impulsive. She forgets she needs help and she just gets up to walk or transfer herself and then she falls.	01620		

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01620	Continued From page 11 -Fall incident report dated April 29, 2026, indicated R1 had a fall in the dining room. -Actions taken to prevent future falls: keep reminding client (resident) to ask for help when wanting to stand up. -Review of fall including a root cause analysis: client (resident) has dementia and is impulsive. She does not ask for help she just gets up and then falls. -Fall incident report dated May 22, 2026, indicated R1 had a fall in the common area. -Actions taken to prevent future falls: Keep reminding client (resident) to ask for assistance when she wants to transfer or ambulate -Review of fall including a root cause analysis: client (resident) forgets she is 91 years old and needs help with ambulation and transfers. She does ask for help occasionally but not always, and when she forgets she usually falls. -Fall incident report dated May 22, 2026, indicated R1 had a second fall in the family room. -Actions taken to prevent future falls: remind client (resident) to ask staff for help if she wants to walk or get up. -Review of fall including a root cause analysis: client (resident) forgets that she needs help to walk and transfer. So when she wants to change positions or go somewhere she attempts on her own and usually ends up falling as is what occurred here. The licensee's RN failed to identify specific root cause analysis of R1's falls and implement interventions to minimize future falls. R2 R2 was admitted on May 1, 2025, with diagnoses that included Parkinson's disease.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41550	A. BUILDING: _____ B. WING _____	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN FIELDS RED WING	522 RIEDELL CT RED WING, MN 55066

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01620	Continued From page 12 R2's service plan dated May 15, 2026, indicated R2 received services to include grooming, dressing, bathing, toileting, incontinence care, escort/mobility assistance, position/re-position, transfer assistance, compression stockings, oxygen, behavior management and medication administration. R2's fall reports and record review from November 26, 2025, through May 26, 2026, indicated the following falls and findings: -Fall incident report dated November 26, 2025, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: resident has dementia and is unable to relay events that proceeded staff finding her on the floor. Unknown if she slid from her bed while sleeping or if she attempted to walk. Staff to keep bed in lowest position. Nursing to discuss with hospice the use of a fall mat by resident's bed as it appears majority of her falls occur near her bed. -Review of fall including a root cause analysis: Resident has dementia and requires assistance with transfers. Resident has multiple diagnoses-Parkinson's disease, HTN (high blood pressure), atrial fibrillation- along with their pharmaceutical treatments that increase her risk of falls. She is currently on hospice services for end of life care. -Fall incident report dated December 3, 2025, indicated R2 had a fall in her bathroom. -Actions taken to prevent future falls: remind client (resident) to ask for help. She has a pendant but did not use it. -Review of fall including a root cause analysis: resident has dementia and requires assistance with transfers. Resident has multiple	01620		

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01620	Continued From page 13 diagnoses-Parkinson's disease, HTN, atrial fibrillation- along with their pharmaceutical treatments that increase her risk of falls. Client (resident) denies that she falls she told staff she wanted to lay on the bathroom floor. -Fall incident report dated December 21, 2025, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: remind client (resident) to ask for help. She has a pendant but did not use it. -Review of fall including a root cause analysis: client (resident) is impulsive and has dementia. She usually falls when she forgets she can't stand or she is trying to get something that is out of reach. -Fall incident report dated December 28, 2025, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: hospice ordered a concave mattress -Review of fall including a root cause analysis: client (resident) does not remember what happened she just woke up on the floor. -Fall incident report dated January 9, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: fall mat was received from hospice -Review of fall including a root cause analysis: resident had dementia and requires assistance with transfers. Resident has concave mattress, pillows on her sides to help position, placed in middle of bed and still falls of out her bed. Falls are unwitnessed so hard to determine if she is attempting to transfer out of bed or truly just "rolls out of bed". -Fall incident report dated January 16, 2026, indicated R2 had a fall in the bathroom.	01620		

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01620	Continued From page 14 -Actions taken to prevent future falls: resident has dementia requiring assistance with ADLs (activities of daily living) and transfers with mechanical lifts. Resident frequently forgets that she is unable to stand and ambulate independently. Resident does not recall that she should use her pendant to call for assistance. Resident has services scheduled for every 1-1.5 hours during awake hours and every three hours on night shift. Staff to anticipate needs and monitor frequently. -Review of fall including a root cause analysis: resident has dementia and requires assistance with transfers. Resident has multiple diagnoses-Parkinson's disease, HTN, atrial fibrillation- along with their pharmaceutical treatments that increase her risk of falls. She is currently on hospice services for end of life care. -Fall incident report dated January 18, 2026, indicated R2 had a fall in the bathroom. -Actions taken to prevent future falls: continue to coordinate with hospice to develop plan to keep resident safe. Writer had conversation with resident regarding her recent fall. She stated that she did not want to fall but she can't walk anymore. Resident prefers to remain in her room, rather than sit in the common area. Staff need to check on resident frequently. -Review of fall including a root cause analysis: resident has dementia and requires assistance with transfers. Resident has multiple diagnoses-Parkinson's disease, HTN, atrial fibrillation-along with their pharmaceutical treatments that increase her risk of falls. She is currently on hospice services for end of life care. -Fall incident report dated January 26, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: Resident	01620		

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01620	Continued From page 15 has diagnoses of dementia requiring assistance with ADLs and transfers with mechanical lifts. Resident receives services from hospice. Resident frequently forgets that she is unable to stand and ambulate independently- she will even report this if questioned on how a fall occurred. Resident does not recall that she should use her pendant to call for assistance. Resident has services scheduled for every 1-1.5 hours during awake hours and every three hours on night shift. Staff to anticipate needs and monitor frequently. Will place reminder sign in resident's room. -Review of fall including a root cause analysis: resident is in the stage of dementia in which she believes she is able to transfer/ambulate without assistance, even though she is in a wheelchair and requires an mechanical stand to transfer. -Fall incident report dated February 6, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: multiple fall interventions have been attempted, however resident frequently forgets that she is unable to stand and ambulate independently. Resident does not recall that she should use her pendant to call for assistance. Resident has dementia and is on hospice services. Staff is frequently in contact with resident and attempt to anticipate her needs. -Review of fall including a root cause analysis: resident has dementia and requires assistance with transfers. Unable to recall that she cannot complete independently. -Fall incident report dated March 5, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: remind client to ask for help so she does not slip out of her w/c. Moved the plants closer to the edge of the table so it is easier to reach them to water	01620		

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01620	Continued From page 16 them. -Review of fall including a root cause analysis: client (resident) wants to do things independently and does not like to ask for help. She also does not always remember that she needs help. -Fall incident report dated March 22, 2026, indicated R2 had a fall near her dresser. -Actions taken to prevent future falls: keep reminding client (resident) to ask for help. -Review of fall including a root cause analysis: client (resident) forgets to ask for help when she wants something which usually results in her ending up on the floor. She almost always denies that she falls even when she does fall. -Fall incident report dated March 27, 2026, indicated R2 had a fall in her bathroom. -Actions taken to prevent future falls: remind client (resident) to ring for help -Review of fall including a root cause analysis: client (resident) does not like to ask for help as she thinks she can self transfer but then she remembers she can't, after she falls. -Fall incident report dated March 29, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: keep reminding client (resident) to use the pendant when she needs help to get out of bed or her w/c or to use the toilet. -Review of fall including a root cause analysis: client (resident) said she crawled out of bed to try sleeping on the matt to see if it was comfortable. No signs or symptoms of injury not sure what really occurred as the client (resident)has a history of making up stories when she falls out of w/c or bed. She did have her pillow with her and under her head when she was found.	01620		

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01620	Continued From page 17 -Fall incident report dated March 31, 2026, indicated R2 had a fall in her bedroom. -Actions taken to prevent future falls: reminders posted in the room to use call light, staff to anticipate needs, service plan reflects services to be provided ever two hours or less. -Review of fall including a root cause analysis: client (resident) has impaired cognition and is impulsive with minimal safety awareness. -Fall incident report dated April 29, 2026, indicated R2 had a fall in the bathroom. -Actions taken to prevent future falls: keep reminding client (resident) to ask for help and use her pendant or the pull cord in the bathroom. -Review of fall including a root cause analysis: client (resident) forgets that she needs help for to get on and off the toilet and for all transfers. When she self transfers, she usually ends up falling. The licensee's RN failed to identify specific root cause analysis of R2's falls and implement interventions to minimize future falls. On May 27, 2026, at 10:19 a.m., clinical nurse supervisor (CNS)-C stated after each fall, she would assess the resident and implement interventions to prevent future falls. However, CNS-C stated R1 and R2's record lacked documentation of specific root cause analysis, and the specific interventions implemented after each fall to prevent future falls. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2022, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident.	01620		

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01620	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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 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: During the entrance conference on May 26, 2026, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to their residents, including medication setup.	01770		

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01770	Continued From page 19 R3 was admitted on May 5, 2026, with diagnoses that included Parkinson's disease. On May 26, 2026, at 12:42 p.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R3 which had been set up by the nurse in a weekly medication box. R3's service plan dated May 15, 2026, indicated R3 received medication administration and medication setup. R3's medication administration record (MAR) dated May 2026, included the following medications: -acetaminophen 500 milligram (mg); take two tablets by mouth twice daily (pain) -amantadine 100 mg; take one tablet by mouth twice a day (Parkinson's disease) -amlodipine 10 mg; take one tablet by mouth daily (blood pressure) -carbidopa/levodopa 25-100 mg; take three tablets by mouth five times daily (Parkinson's disease) -celecoxib 200 mg; take one tablet by mouth daily (pain) -chlorthalidone 25 mg; take one tablet by mouth daily (blood pressure) -escitalopram 10 mg; take one tablet by mouth daily (depression) -gabapentin 300 mg; take three capsules by mouth twice daily (pain) -lisinopril 20 mg; take one tablet by mouth daily (blood pressure) -methadone 10 mg; take one and one-half tablet by mouth every morning (pain) -omeprazole 40 mg; take one capsule by mouth daily (reflux) -oxycodone 15 mg; take one tablet by mouth twice daily (pain)	01770		

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01770	Continued From page 20 -senna plus 8.6-50 mg; take four tablets by mouth twice daily (constipation) -lorazepam 0.5 mg; take one tablet by mouth every night at bedtime (anxiety) -methadone 10 mg; take one tablet by mouth every night at bedtime (pain) -trazodone 50 mg; take two tablets by mouth at bedtime (sleep) R3's service recap summary dated May 2026, included documentation for the following: -Medication Setup (TU) on May 26, 2026 -Nursing Service: Unscheduled Visit: Set up Medibox on May 15, 2026 -Nursing Service: Unscheduled Visit: Delayed entry. Set up Medibox as ordered on May 19, 2026 R3's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On May 27, 2026, at 10:16 a.m., CNS-C stated she documented the completion of the medication set up for R3 on the service recap summary. CNS-C stated she did not document the name of each medication, quantity of dose, time to be administered, or route of administration when setting up any residents' medications. The licensee's Medication Management- Dosage Box Setup policy dated August 1, 2021, indicated the following: 1. A licensed nurse will assure the medication orders are transcribed onto the MAR. This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose	01770		

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01770	Continued From page 21 d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 2. The licensed nurse transcribes the medications order onto the MAR. For medications included in the dosage box, the day and time of administration will be noted on the MAR. 3. Medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and: a. Medication name b. Quantity of dose c. Times to be administered d. Route of administration e. Visual description of medication f. Drug classification and special precautions 4. The licensed nurse sets up medication weekly into the dosage boxes. 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. 6. The licensed nurse will review the dosage boxes on a weekly basis to assure that all the previous week's medications were administered, and documentation is then made on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		

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

Food & Beverage Inspection Report

Establishment Info

ELYSIAN FIELDS RED WING
522 RIEDELL CT
Red Wing, MN 55066
Goodhue County
Parcel:

Phone:

License Info

License: HFID 41550

Risk:
License:
Expires on:
CFPM: Susanne M. Tesch
CFPM #: 124926; Exp: 08/29/2027

Inspection Info

Report Number: F8044261158
Inspection Type: Full - Single
Date: 5/27/2026 Time: 8:59:57 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 4
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12B *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.
COMMENT: Bowls in bulk cereal containers used for portioning, rather than a scoop with a handle.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.12 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0305 Do not store food in locker rooms, toilet rooms, dressing rooms, garbage rooms, mechanical rooms, under unprotected sewer lines, under leaking water lines, under water lines on which water has condensed, under open stairwells, or under other sources of contamination.
COMMENT: Soy sauce, vinegar and other bottled foods stored beneath unprotected sewer line for handwashing sink in grill area.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

New Order: 3-500A Microbial Control: cooling
3-501.13E *Priority Level: Priority 3 CFP#: 35*
MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.
COMMENT: Frozen fish thawing in vacuum sealed bags.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: Dates missing from opened packages of sliced deli meats in reach-in cooler.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

! **New Order: 5-400 Sewage**
5-402.11A *Priority Level: Priority 1 CFP#: 52*
MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.
COMMENT: No air gap with floor drain for ice machine drain hose.
Comply By: 6/8/2026 Originally Issued On: 5/27/2026

New Order: 5-500 Refuse and Recyclables
5-501.17 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1260 Provide covered receptacles in the toilet room for sanitary napkins or diapers.
COMMENT: No covered trash can in either restroom.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Emily Boxrud.

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 F8044261158 from 5/27/2026

Emily Boxrud
VP

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

ELYSIAN FIELDS RED WING
Red Wing
County/Group: Goodhue County

Inspection Info

Report Number: F8044261158
Inspection Type: Full
Date: 5/27/2026
Time: 8:59:57 AM

Food Temperature: Product/Item/Unit: Cream**; Temperature Process:** Cold-Holding
Location: Upright Cooler 1 at 39.9 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 1 at 37.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sauerkraut**; Temperature Process:** Cold-Holding
Location: Upright Cooler 2 at 38.1 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 2 at 37.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced deli ham**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 37.3 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Reach-in Cooler at 35.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler 3 at 38.1 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 3 at 34.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

ELYSIAN FIELDS RED WING
Red Wing
County/Group: Goodhue County

Inspection Info

Report Number: F8044261158
Inspection Type: Full
Date: 5/27/2026
Time: 8:59:57 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 162.7 Degrees F.
Comment:
Violation Issued?: No

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

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

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