



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 26, 2026

Licensee

Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

RE: Project Number(s) SL33414016

Dear Licensee:

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

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

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

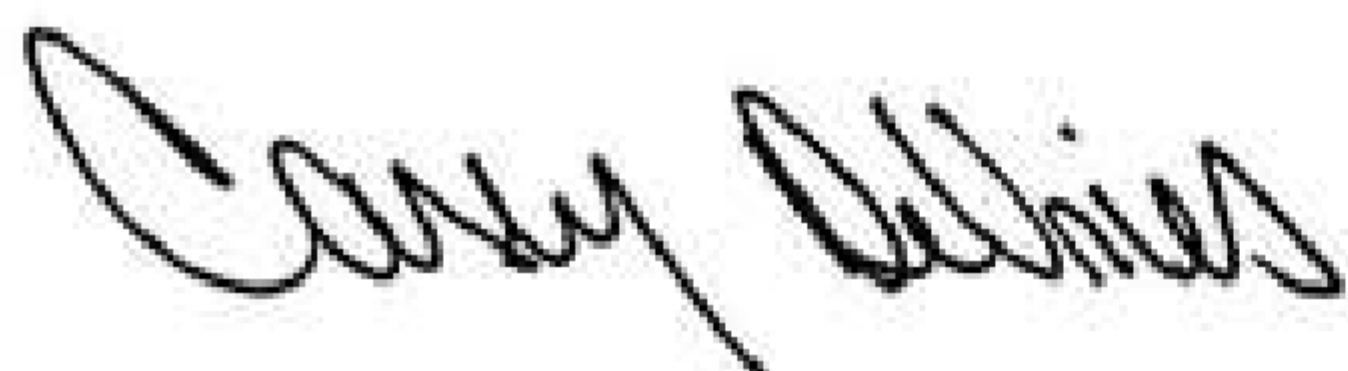
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: \1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER SUNCREST ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 WASHINGTON AVENUE SCANLON, MN 55720			
(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: SL33414016-0 On March 9, 2026, through March 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 40 residents; 21 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 10, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. This had	0 680			

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0 680	Continued From page 4 the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 9, 2026, at 1:19 p.m., during a tour of the facility with clinical nurse supervisor (CNS)-A, the surveyor requested to see a copy of the licensee's EPP. CNS-A was initially unable to locate the EPP and needed to call for assistance in locating the licensee's EPP. CNS-A was able to eventually locate the licensee's EPP in the nursing office. The licensee's Emergency Plan dated August 23, 2024, lacked evidence of the following required content: - documentation of an annual review of the EPP; - policies and procedures regarding at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - policies and procedures for the process of cooperation and collaboration with local, tribal, regional, state and federal EP to maintain integrated response; - annual review of policies and procedures based on risk assessment; - documentation of arrangements with other facilities/providers to receive residents in the	0 680			

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0 680	Continued From page 5 event of limitations/cessation of operations to maintain the continuity of services to residents; - documentation of the annual review of the communication plan, and; - contact information for federal, state, tribal, regional & local EP staff, state licensing and certification agency, MN Office of Ombudsman for LTC, and other sources of assistance. The licensee's undated Emergency Preparedness - Training, Exercise, and Evaluation policy indicated that at least annually, the licensee would evaluate their Emergency Preparedness - Disaster Plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 775			

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0 775	Continued From page 6 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800			

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0 800	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 8 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810			

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0 810	Continued From page 9 Environment Inspection Report (PEIR) dated March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620			

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01620	Continued From page 10 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) completed ongoing resident reassessments at least every 90 days for two of two residents (R2, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER SUNCREST ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 WASHINGTON AVENUE SCANLON, MN 55720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 11 R2 R2 was admitted July 24, 2013, and began receiving assisted living services on August 1, 2021. R2's diagnoses included radiculopathy, spondylosis of lumbar region, chronic pain, rheumatoid arthritis, abnormalities of gait and mobility, generalized anxiety disorder, age-related osteoporosis without current pathological fracture, and chronic obstructive pulmonary disease with (acute) exacerbation. R2's service plan dated May 21, 2025, indicated R2 received assistance with mobility and ambulation, medication management, bathing, meals, housekeeping, shopping, transportation, and activities. R2's most recent 90-day assessment was dated February 24, 2026, with their next most recent assessment occurring on November 17, 2025, which indicated 99 days had lapsed between assessment dates. R2's next most recent assessment was dated August 18, 2025, which indicated 92 days lapsed between assessments. R3 R3 was admitted on August 7, 2024, to receive assisted living services. R3's diagnoses included essential hypertension, depression, chronic cough, hypothyroidism, tinea cruris, gastro-esophageal reflux disease, acute pain, and constipation. R3's service plan dated August 26, 2025, indicated R3 received assistance with mobility and ambulation, medication management,	01620			

Minnesota Department of Health

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01620	Continued From page 12 bathing, grooming, toileting, meals, housekeeping, shopping, transportation, activities, skin care, and well-being checks. R3's most recent 90-day assessment was dated February 13, 2026, with their next most recent 90-day assessment occurring on October 23, 2025, which indicated 114 days had lapsed between assessment dates. R3's record contained an additional 90-day assessment occurring on October 20, 2025, three days prior to the October 23, 2025, assessment. The next assessment found in R3's record occurred on May 16, 2025, which indicated 157 days had lapsed between assessment dates. On March 11, 2026, at 12:31 p.m., clinical nurse supervisor (CNS)-A stated they were aware of the required 90-day assessments windows, and that they were newer to the position and was still learning the position at the time of these assessments. CNS-A stated the assessments were late due to an error in timekeeping. The licensee's undated Nursing Assessment policy indicated a registered nurse would complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required on pre-admission, up to 14-days after start of services, and ongoing but no less than every 90-days or with changes in resident conditions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			

Minnesota Department of Health

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01710	Continued From page 13	01710			
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) conducted an accurate medication assessment for two of three residents (R5, R6) observed receiving medication administration. 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: R5 R5 was admitted on January 8, 2025, to receive assisted living services. R5 service plan dated July 2, 2025, indicated R5 received assisted living services to include	01710			

Minnesota Department of Health

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01710	Continued From page 14 mobility and ambulation, transfers, medication management, bathing, grooming, dressing, toileting, meals, laundry, shopping, transportation, and activities. Additionally, R5's medication management plan indicated medication would be stored in a locked cabinet in the resident's apartment. R5's assessment dated January 2, 2026, indicated R5's medication was to be stored in a locked cart in a central location. On March 10, 2026, at 7:38 a.m., the surveyor observed a bottle of Nitroglycerin 0.4mg sublingual tablets on a table near R5's recliner. R6 R6 was admitted on December 26, 2025, to receive assisted living services. R6 service plan dated December 30, 2025, indicated R6 received assisted living services to include mobility and ambulation, transfers, medication management, bathing, grooming, dressing, toileting, shopping, transportation, activities, and housekeeping. Additionally, R6's service plan indicated medications were to be stored in medication carts. R6's assessment dated January 6, 2026, indicated R6's medications were to be stored in a locked cart in a central location. On March 10, 2026, at 7:58 a.m., the surveyor observed three plastic bags labeled morning noon and night. The surveyor observed vials of Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5%, and Brimonidine Tartrate Ophthalmic Solution 0.2 % in the bag labeled AM. Unlicensed personnel (ULP)-C stated R6's family	01710			

Minnesota Department of Health

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01710	Continued From page 15 had set up their medications in the bags so that administration of medications would be easier for staff. On March 11, 2026, at 12:36 a.m., clinical nurse supervisor (CNS)-A stated they were aware R5 and R6 had been assessed as needing secure central storage of medications but had assumed that since their apartment doors were lockable, it met the requirement of being secured. The licensee's undated Storage of Medications policy indicated the registered nurse would identify where medications would be stored, understanding that the licensee may not be able to control where and how a resident stores their medications in their apartment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for one of three residents (R6) observed receiving medication administration.	01890			

Minnesota Department of Health

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01890	Continued From page 16 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: R6 was admitted on December 26, 2025, to receive assisted living services. R6's service plan dated December 30, 2025, indicated R6 received assisted living services to include mobility and ambulation, transfers, medication management, bathing, grooming, dressing, toileting, shopping, transportation, activities, and housekeeping. Additionally, R6's service plan indicated medications were to be stored in medication carts. On March 10, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R6. On March 10, 2026, at 2:53 p.m., the surveyor completed an audit of the medication storage cart and observed R6's medication storage and a bottle of Metoprolol succinate ER 25mg (milligram), half tablet with an expiration date of February 13, 2025. On March 11, 2026, at 12:39 a.m., clinical nurse supervisor (CNS)-A stated staff were trained to check medications for expiration dates. CNS-A stated the medication had been brought in by R6	01890			

Minnesota Department of Health

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01890	Continued From page 17 during their admission. CNS-A stated they try to use up personal medications prior to reordering due to insurance, but it was missed due to an oversight. CNS-A stated they would reorder the medication right away for R6. The licensee's undated Storage of Medication policy indicated the licensee would ensure all medications are subject to proper handling and storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720
Carlton County
Parcel:

Phone:

License Info

License: HFID 33414

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1016261050
Inspection Type: Full - Single
Date: 3/10/2026 Time: 10:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery:

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: A SERVSAFE OR CFPM CERTIFICATE WAS NOT AVAILABLE. OBTAIN CFPM CERTIFICATE AND POST.

Comply By: 3/27/2026 Originally Issued On: 3/10/2026

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

3-302.12 Priority Level: Priority 3 CFP#: 37

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

COMMENT: BROWN SUGAR IN BULK CONTAINER DID NOT HAVE A LABEL. LABEL ALL ITEMS OUTSIDE OF ORIGINAL PACKAGING.

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A Priority Level: Priority 3 CFP#: 39

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

COMMENT: FOOD PACKAGES IN FREEZER WERE NOT CLOSED. CLOSE ALL FOOD PACKAGES TO PROTECT AGAINST CONTAMINATION.

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A Priority Level: Priority 3 CFP#: 55

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

COMMENT: KITCHEN CABINETS HAD PAINT PEELING. REPAIR OR REPLACE CABINETS. COUNTERS HAD FOOD CRUMBS EVEN THOUGH FOOD WAS NOT BEING PREPARED AT TIME OF INSPECTION. DISH WASHER HAD BUILDUP INSIDE. UPRIGHT COOLER IN SECONDARY KITCHEN NEEDS CLEANING. CLEAN ALL AREAS OF FOOD DEBRIS OR BUILDUP.

Comply By: 3/13/2026 Originally Issued On: 3/10/2026

Food & Beverage General Comment

COMMENTS:

MAJORITY OF FOOD IS CATERED BY BOWLZ N' THANGZ, LLC DULUTH MN HOWEVER SOME FOOD IS REHEATED ON SITE

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 Duluth District Office inspection report number F1016261050 from 3/10/2026

Establishment Representative



Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Page: 1

Establishment Info

Suncrest Assisted Living
Scanlon
County/Group: Carlton County

Inspection Info

Report Number: F1016261050
Inspection Type: Full
Date: 3/10/2026
Time: 10:30 AM

Food Temperature: Product/Item/Unit: RELISH; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN; **Temperature Process:** Cold-Holding

Location: Upright Freezer at Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN; **Temperature Process:** Cold-Holding

Location: Chest Freezer at Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL33414016	Date: 3/10/2026
Facility Name: Suncrest Assisted Living	
Facility Address: 2400 Washington Ave. Scanlon, MN 55720	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: The two emergency exit doors on the west side of the building, did not have the snow removed so that there was a clear pathway leading to a public way. Once outside the building the terrain leading to the parking lot was unlevel and had a steep incline.

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

Comments: The annual fire sprinkler system(s) report done on May 21, 2025, listed deficiencies with the systems. Maintenance (M)-F stated that he was aware of these deficiencies and that they are working on getting them repaired.

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

Comments: There was a designated smoking area with a cigarette butt receptacle provided in front of the building, but there was evidence of smoking due to cigarette butts lying on the ground.

5. 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: Labeled fire doors in the following locations did not close and latch: resident rooms 201 and 218, and the main front entrance door leading into the corridor.

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

Comments: There was a popcorn machine, a stool, and games stored in the hallway that led to the emergency exit doors on the west side of the building.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: There was a hole in the wall above the boiler room. Boxes with papers and filing cabinets were stored in front of an electrical panel and by the heat/AC unit in the furnace room.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP inaccurately referenced housekeeping, dining and administration, which this facility does not have this type of staffing. The plan also referenced that staff check the fire panel located in the lobby of the terrace and the suites, which were not part of this facility. This plan also included the R.A.C.E. (Rescue, Alarm, Contain, Evacuate or Extinguish) acronym, which did not clearly identify employee actions that were specific to this facility. The name on the policy did not match the licensee's facility name.

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

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP did not mention the fire protection procedures necessary for residents.

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

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with no unique or unusual needs for movement or evacuation for residents to take in the event of a fire or similar emergency. The FSEP included instructions to evacuate residents, but did not include the identification of residents that needed assistance or any resident-specific needs or procedures for staff to assist residents during evacuation. The name on the policy did not match the licensee's facility name.