



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 20, 2026

In the Matter of Access Minnesota LLC
Access Minnesota LLC
335 37th Avenue North
Saint Cloud, MN 56303

RE: MDH Health Facility Identification Number 35571
License Number 419961
Project Number(s) SL35571016

Dear Licensee:

STIPULATION AND CONSENT ORDER:

It is stipulated and agreed by Access Minnesota LLC and the Minnesota Department of Health ("Department" or "MDH"), that without a hearing or adjudication under the procedures outlines in Minn. Stat. § 144G.20 or Minn. Stat § 144G.32, both parties agree to enter into this stipulation and consent order.

This Stipulation and Consent Order ("Stipulation"), survey reports, and related documents shall constitute the entire record upon which this Stipulation is based. The survey results and public documents dated March 5, 2026, through the date of this Stipulation, as listed below in the Facts and Law, are incorporated by reference into this Stipulation. This Stipulation is public data pursuant to Minn. Stat. § 144.051, Subd. 4 (6) and the provisions of the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13.

FACTS AND LAWS:

1. Minn. Stat. § 144G.01 - Minn. Stat. § 144G.95, authorize MDH to regulate licensed assisted living facilities in Minnesota. This authority includes issuing licenses and conducting surveys to determine if a license holder is in compliance with statutory requirements of licensed assisted living facilities.
2. Access Minnesota LLC has been licensed to provide assisted living services since .
3. On March 5, 2026, the Department conducted a full survey for the purpose of assessing compliance with State licensing regulations (Project Number(s) SL35571016). This survey resulted in 30 order(s), including 20 Level 2/Widespread, 2 Level 3/Widespread.

CURRENT STATUS:

Access Minnesota LLC President, Garat Ibrahim met informally with MDH during a conference call on May 7th, 2026. During this call, MDH shared their concerns about the survey completed on March 5, 2026 and provided Access Minnesota LLC with the option of a stipulated agreement. During the informational conference, Access Minnesota LLC shared what actions they are taking to

bring Access Minnesota LLC into compliance. Additional communications followed, and Access Minnesota LLC decided to proceed with a stipulated agreement. Under this agreement, Access Minnesota LLC will take immediate steps to correct all violations while operating under a conditional license.

CONDITIONAL LICENSE ISSUED:

MDH will issue Access Minnesota LLC a conditional assisted living facility license for 90 calendar days from the effective date of this Stipulation. Conditional licenses are addressed in Minn. Stat. § 144G.20. The conditions will be effective immediately upon execution of this stipulation and consent order. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30 Subd. 6. Based on the results of the survey, MDH will determine if Access Minnesota LLC is in compliance. If the licensee is in substantial compliance, conditions will be lifted.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Access Minnesota LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Access Minnesota LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Access Minnesota LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Access Minnesota LLC will contract with an RN to provide consultation concerning all resident(s) to whom Access Minnesota LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Access Minnesota LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the

consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Access Minnesota LLC and MDH must review the RN's credentials and approve the selection. Access Minnesota LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Access Minnesota LLC in an effort to help Access Minnesota LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Access Minnesota LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Access Minnesota LLC and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:
- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Access Minnesota LLC to correct the violations cited during the survey as well as to determine the overall practice of Access Minnesota LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary

suspension or revocation of the license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

- g. Corrective Action Plan:** Access Minnesota LLC will develop and work within a corrective action plan (CAP)(Minn. Stat. § 144G.30, Subd. 5 (c). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of corrections
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP SURVEY DURING THE CONDITIONAL LICENSE PERIOD: MDH will determine if Access Minnesota LLC is in compliance based on the results of the follow up survey conducted pursuant to Minn. Stat. § 144G.30, Sub. 6. MDH will make this determination within the 90-day conditional license period. If MDH determines Access Minnesota LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Access Minnesota LLC's assisted living facility license, and Access Minnesota LLC will correct violations detected during the survey to come into full compliance. If MDH determines Access Minnesota LLC is not in substantial compliance, MDH may take additional enforcement action against Access Minnesota LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

RIGHTS AND WAIVERS:

Under this Stipulation and Consent Order, Access Minnesota LLC waives all appeal rights outlined in Minn. Stat. § 144G.20 and Minn. Stat. § 144G.32 related to the referenced survey findings and the conditional assisted living facility license under the terms and duration noted above. Any pending requests for hearing or reconsideration related to these survey findings are rescinded. Access Minnesota LLC retains all applicable appeal rights outlined in Minn. Stat. Chapter 144G for any enforcement action not outlined in this agreement.

FINES RESCINDED:

Under this Stipulation and Consent Order, MDH rescinds the fines assessed in the letter concerning the survey completed on March 5, 2026. The rescinded fines include those associated with order number(s) 0510, 0775, 0780, 0810, and 1750 totaling \$3,500.00. The correction orders outlined in the April 22, 2026 State Form remain in effect.

BINDING EFFECT:

This Stipulation and Consent Order is binding upon the Parties, their employees, agents, heirs, administrators, representatives, executors, successors and assigns, and the Parties will assure that their employees, agents, heirs, administrators, representatives, executors, successors, and

assignees are made aware of this Order.

NO LIMITED AUTHORITY:

This Stipulation does not in any way or manner limit or affect the authority of MDH to take additional enforcement action against Access Minnesota LLC based on any act, conduct, or admission of Access Minnesota LLC which justifies enforcement action and occurred either before or after the date of this Stipulation and which is not directly related to the facts and circumstances covered in this Stipulation.

SERVICE OF AGREEMENT AND VENUE:

MDH will provide a signed electronic copy of the Stipulation and Consent Order to Access Minnesota LLC. By this Stipulation, Access Minnesota LLC agrees that the signed and scanned copy of the Stipulation is considered to be personal service upon Access Minnesota LLC and at which time this Stipulations becomes effective. Disputes regarding the meaning of this Stipulation and Consent Order or actions to enforce this Order shall be venued in Ramsey County District Court, St. Paul, Minnesota.

ENTIRE AGREEMENT:

This Stipulation and Consent Order contains the entire agreement between Access Minnesota LLC and MDH, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Order. Access Minnesota LLC understands that this agreement is subject to the Division Director's approval.

RIGHT TO COUNSEL:

Access Minnesota LLC is aware of the right to be represented by counsel. Access Minnesota LLC was represented by [Insert attorney name or remove if not represented.]

ACKNOWLEDGEMENT:

Access Minnesota LLC hereby acknowledges that is has read, understands, and agrees to this Stipulation and Consent Order and has freely and voluntarily signed it.

Access Minnesota LLC

,

Dated: _____, 2026

This Stipulation and Consent Order is effective upon signature by MDH and the Licensee.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

Rick Michals, J.D., Executive Regional Operations Manager

Date: _____, 2026

Electronically Delivered
May 19, 2026

In the Matter of Access Minnesota LLC
Access Minnesota LLC
335 37th Avenue North
Saint Cloud, MN 56303

RE: MDH Health Facility Identification Number 35571
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Project Number(s) SL35571016

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ACKNOWLEDGEMENT:

Access Minnesota LLC hereby acknowledges that it has read, understands, and agrees to this Stipulation and Consent Order and has freely and voluntarily signed it.

Access Minnesota LLC

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Dated: _____, 2026

This Stipulation and Consent Order is effective upon signature by MDH and the Licensee.

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

Maria King, RN, Division Director

CLN

RESCINDED



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 22, 2026

Licensee

Access Minnesota LLC
335 37th Avenue North
Saint Cloud, MN 56303

RE: Project Number(s) SL35571016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Access Minnesota. **Please contact Kelly Thorson at 320-223-7336 on or before April 27, 2026 to schedule the conference call.**

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 cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
(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: SL35571016-0 On March 3, 2026, through March 5, 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 two residents who both received services under the Assisted Living Facility license. An immediate correction order was identified on March 4, 2026, issued for SL35571016-0, tag identification 1750. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
(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
0 340	Continued From page 1 (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0100, 0470, 0480, 0630, 0680, 0800, 0810, 0970, 1440, 1470, 1500, 1610, and 1910) for a survey completed on June 28, 2024. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
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0 340	Continued From page 2 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 March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. On March 3, 2026, at 11:23 a.m., LALD/CNS-A provided the licensee's Actions Taken to Comply with the Correction Orders dated July 31, 2024, which included the licensee's plan of corrections for correction orders 0650 and 1290. The licensee lacked documentation to indicate correction orders previously cited on June 28, 2024, were in full compliance with assisted living statutes. On March 3, 2026, LALD/CNS-A stated additional plan of corrections documents were not created for the above citations. LALD/CNS-A further stated the licensee believed the plan of corrections was only required for citations addressed during the follow-up survey. On March 4, 2026, the survey concluded, and correction orders 0470, 0480, 0630, 0680, 0800, 0810, 0970, 1440, 1470, 1500, and 1910 were reissued. No further information was provided.	0 340			

Minnesota Department of Health

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0 340	Continued From page 3	0 340			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a 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: The licensee held an assisted living facility license and was licensed for a capacity of five residents, with a current census of two residents. During the entrance conference on March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. On March 3, 2026, at 9:50 a.m., LALD/CNS-A stated the licensee scheduled the following unlicensed personnel (ULPs) for each shift: - day shift 7:00 a.m. through 3:00 p.m., one ULP was scheduled; - evening shift 3:00 p.m. through 11:00 p.m., one ULP was scheduled; and - night shift 11:00 p.m. through 7:00 a.m., one ULP was scheduled. On March 4, 2026, at 2:58 p.m., LALD/CNS-A	0 470			

Minnesota Department of Health

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0 470	Continued From page 5 stated the licensee did not have a staffing plan developed by a registered nurse. LALD/CNS-a further stated LALD/CNS-A was unaware of the requirement for a staffing plan and acknowledged LALD/CNS-A and licensee staff discussed resident needs and scheduled staff as was seen fit for current residents. The licensee's Staffing policy dated October 15, 2025, indicated the CNS prepared and implemented a 24-hour daily staffing plan that ensured adequate staffing was scheduled to meet resident's needs at all times, including reasonably foreseeable needs. The policy further indicated the staffing plan was evaluated as part of the Quality Management program at least twice per year with results documented in meeting minutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	0 480			

Minnesota Department of Health

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0 480	Continued From page 6 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 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.	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 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 3, 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 to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal	0 485			

Minnesota Department of Health

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0 485	Continued From page 8 fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. On March 2, 2026, at 9:28 a.m., LALD/CNS-A stated payment for three meals per day was	0 485			

Minnesota Department of Health

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0 485	Continued From page 9 included as part of the monthly assisted living contract rate. On page three of the undated (licensee name) Assisted Living Contract, section labeled Primary Services read, "Subject to the Resident's needs, [licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day and (2) snacks are served in the dining area as planned and prepared by [licensee] staff at the following times: 9:00 AM (sic) Breakfast; 12:00 PM Lunch (sic); and 6:00 PM Dinner (sic)." Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On March 4, 2026, at 2:59 p.m., LALD/CNS-A stated the licensee was aware the licensee was required to provide an option for residents to opt out of one, two, or three meals however, the contract had not yet been updated. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of two employees (unlicensed personnel (ULP)-C, ULP-E). 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 March 3, 2026, at 9:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided assistance with medication management and meals to residents at the facility.	0 510			

Minnesota Department of Health

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0 510	Continued From page 11 On March 4, 2026, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-E apply gloves without performing hand hygiene. ULP-E proceeded to prepare and administer R2's scheduled medications. ULP-E then removed ULP-E's gloves and without performing hand hygiene, proceeded to complete end of shift responsibilities before leaving the facility. On March 4, 2026, at 7:37 a.m. through 8:09 a.m., the surveyor observed ULP-C complete medication administration and meal preparation for residents at the facility. ULP-C performed hand hygiene, applied gloves, prepared and administered scheduled medication to R1. ULP-C then removed ULP-C's gloves and without performing hand hygiene or applying new gloves, ULP-C removed four frozen waffles from the freezer and placed them in the toaster. ULP-C then applied gloves without performing hand hygiene to peel hard boiled eggs, placed the food on a plate for R1. Without removing gloves or performing hand hygiene, ULP-C held onto the stair railing and walked downstairs to notify R1 that breakfast was ready. R1 declined their meal at that time and ULP-C returned to the kitchen and without changing gloves or performing hand hygiene, ULP-C covered the plate of food with aluminum foil and placed it in the microwave. On March 4, 2026, at 7:34 a.m., ULP-E stated ULP-E was trained to perform hand hygiene before and after giving medications and before food preparation. ULP-E further stated that ULP-E had just completed working the night shift and was tired and forgot to wash ULP-E's hands before applying gloves. On March 4, 2026, at 3:35 p.m., LALD/CNS-A	0 510			

Minnesota Department of Health

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0 510	Continued From page 12 stated staff were trained to perform hand hygiene before and after each resident interaction, before and after wearing gloves, and before and after handling food. LALD/CNS-A further stated staff were trained to wear gloves when performing medication administration, preparing food, or when cleaning and that the gloves were expected to be changed between tasks even for the same resident. The licensee's Infection Control policy dated August 1, 2025, indicated employee hands were washed before assisting with medications, after housekeeping, before preparing food, and after removing gloves. The policy further indicated gloves were worn when touching blood, body fluids, secretions, excretions, nonintact skin, mucous membranes, or contaminated items. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	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.	0 630			

Minnesota Department of Health

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0 630	Continued From page 13 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 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 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 March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. R1 R1's diagnoses included schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior), anxiety, and depression. R1's Service Plan dated February 11, 2026, indicated R1's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C	0 630			

Minnesota Department of Health

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0 630	Continued From page 14 administer R1's scheduled morning medication. R1's IAPP dated February 12, 2026, indicated R1 was at risk of being abused by others and not at risk of abusing themselves. R1's record lacked R1's risk of abusing other vulnerable adults and the specific measures taken to minimize the risk. R2 R2's diagnoses included schizophrenia and anxiety. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's IAPP dated July 24, 2024, indicated R2 was at risk of being abused by others and not at risk of abusing themselves. R2's record lacked R2's risk of abusing other vulnerable adults and the specific measures taken to minimize the risk. On March 4, 2026, at 3:05 p.m., LALD/CNS-A stated all residents were considered vulnerable adults and the risk of abusing others was supposed to be included on the IAPP. LALD/CNS-A further stated LALD/CNS-A was uncertain why a resident's risk of abusing others was not included on the assessments. The licensee's Vulnerable Adult policy dated August 1, 2025, indicated each resident had an IAPP established which addressed the resident's susceptibility to abuse by another individual, the resident's risk of abusing other vulnerable adults, and specific measures to be taken to minimize	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
(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
0 630	Continued From page 15 the risk of abuse to the resident and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records	0 650			

Minnesota Department of Health

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0 650	Continued From page 16 included all required content for three of three unlicensed personnel ((ULP)-C, ULP-D, ULP-E). 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: ULP-C ULP-C was hired on August 21, 2020, under the licensee's previous comprehensive license and began providing assisted living services on August 1, 2021. ULP-C's employee record included a Performance Evaluation completed August 16, 2020. ULP-C's employee record lacked performance evaluations for the years 2021, 2022, 2023, 2024, and 2025. ULP-D ULP-D was hired on December 4, 2025, and began providing assisted living services. ULP-D's employee record included Staff Orientation Record completed December 6, 2026, indicated the orientation met the requirements of 245D home and community-based services (HCBS). The document indicated ULP-D received a job description and specific job function as required under 245D.09 subd. 3 on November 28, 2025. ULP-D's employee record lacked a position	0 650			

Minnesota Department of Health

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0 650	Continued From page 17 description for job functions under statues 144G. In addition, ULP-D's employee record lacked evidence of the following required trainings: - maintenance of a clean and safe environment; - care and use of hearing aids; -communication skills that included preserving the dignity of the resident and showing respect for the resident and resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding boundaries between staff and resident and the resident's family; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported; - vital signs; and - recognizing physical, emotional, cognitive, and developmental needs of resident. ULP-E ULP-E was hired on June 26, 2024, and began receiving assisted living services. ULP-E's employee record included an undated form titled Performance Evaluation. The form showed three of the 20 performance areas addressed and lacked signatures from the employee and supervisor. ULP-E record lacked performance review for the year 2025. In addition, ULP-E record lacked the following required trainings and competency evaluations: training: - maintenance of a clean and safe environment; - care and use of hearing aids; - communication skills that included preserving the dignity of the resident and showing respect for the resident and resident's preferences, cultural background, and family; - awareness of confidentiality and privacy;	0 650			

Minnesota Department of Health

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0 650	Continued From page 18 - understanding boundaries between staff and resident and the resident's family; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported; - vital signs; and - recognizing physical, emotional, cognitive, and developmental needs of resident. competency evaluations: - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, oral care, use of hearing aides, toileting, and dressing; - stand by assistance and how to perform them; - vital signs; - Safe transfer techniques and ambulation; and - range of motion. On March 4, 2026, at 10:58 a.m., ULP-D stated they received all of the training topics listed above and licensed practical nurse (LPN)-F, administrative assistant/unlicensed personnel (AA/ULP)-B and agent/owner (A/O)-G trained them on the topics. On March 4, 2026, at 11:57 a.m., the surveyor attempted to contact ULP-E via phone. The surveyor was not successful and was unable to leave a voicemail because the mailbox was full. On March 4, 2026, at 2:38 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP's received the required 22 areas of training and competency evaluations if they were not a certified nursing assistant (CNA). LALD/CNS-A stated they completed all trainings with ULP-D and ULP-E however believe the paperwork was misplaced. LALD/CNS-A	0 650			

Minnesota Department of Health

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0 650	Continued From page 19 stated they believed an employee who filed the employee's paperwork believed a certification of completion was all that needed to be placed into the employee record. On March 4, 2026, at 2:50 p.m., LALD/CNS-A stated performance reviews were completed annually by the licensee's administration. LALD/CNS-A stated they believed another employee did not place the performance reviews in the employee record because the employee was confused about what items needed to go into the employee record. LALD/CNS-A stated job descriptions were provided to the ULP when ULP filled out an application to be hired. LALD/CNS-A stated job descriptions should be located in the employee record and if they were not in the employee record, they were unsure why they were not there. LALD/CNS-A stated they were unable to find the performance reviews and the job descriptions. The licensee's Personnel Records dated August 1, 2025, indicated performance reviews, and a signed job description would be kept in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	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	0 660			

Minnesota Department of Health

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0 660	Continued From page 20 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a TB facility risk assessment, TB health history symptom screen for two of three employees ((ULP)-D, ULP-E), and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three employees (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 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: The licensee's Facility TB Risk Assessment	0 660			

Minnesota Department of Health

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0 660	Continued From page 21 Worksheet for Health Care Setting Licensed by MDH* dated September 22, 2025, indicated the licensee TB risk level was low. Page 11 of the assessment was partially filled in by the licensee and the areas not addressed included who maintained TB records, where TB records were stored, annual conversion rate, categories of health care personnel included in baseline TB screening program, and if annual screening needed to be conducted. ULP-D ULP-D was hired on December 4, 2025, and began providing assisted living services. ULP-D employee record included a first step TST completed during the survey on March 3, 2026. ULP-D record lacked a second step TST and lacked TB health history symptom screening. ULP-E ULP-E was hired on June 26, 2024, and began receiving assisted living services. ULP-E employee record included a negative chest Xray completed after a positive TST dated March 5, 2024. ULP-E record lacked a TB health history symptom screen. On March 4, 2026, at 2:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated new hires were screened for TB at a clinic. LALD/CNS-A stated the licensee received test results and placed them into the employee file. LALD/CNS-A stated they do not conduct the initial TB health history screen because it is completed at the clinic prior to the employee receiving their TB screen however, they would complete a TB health history screen yearly after the date of hire. LALD/CNS-A stated	0 660			

Minnesota Department of Health

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0 660	Continued From page 22 agent/owner (A/O)-G was responsible for reviewing the TB results and placing them into the employee file. LALD/CNS-A stated they did not know why ULP-D had not completed a two-step TST. LALD/CNS-A stated a health history screen was not needed for ULP-E because their chest Xray was negative. LALD/CNS-A stated they did not know why the TB facility risk assessment was not filled in completely. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; - a TB test which could include TB blood test or TB skin test; and - additional evaluation for TB disease as needed. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQs) dated October 13, 2025, indicated providers were required to complete a TB risk assessment annually. Completion of the TB facility risk assessment would assist providers in the development of an infection control committee and determine the frequency of screening. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2025, indicated the licensee would observe the recommended precautions related to TB as identified by the CDC and MDH. The precaution included the following elements: - risk assessment; - TB screening; and	0 660			

Minnesota Department of Health

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0 660	Continued From page 23 - staff education. In addition, baseline screening included an assessment for TB history and current TB symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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.	0 680			

Minnesota Department of Health

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0 680	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. 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, 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 March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. The licensee's undated EPP lacked the following content and/or policies and procedures to address: - an EPP available for all staff, residents, and volunteers to access; - annual review of the EPP; - a missing resident plan that was reviewed quarterly: Missing Resident policy provided was effective August 1, 2025, and lacked documentation of review dates; - identification of resident needs like maintaining	0 680			

Minnesota Department of Health

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0 680	Continued From page 25 independence, communication, transportation, supervision, and medical care needs provided by the licensee; - the provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting); - system to track the location of on-duty staff and residents; - a policy and procedure including an evacuation plan to include staff responsibilities during an evacuation; - a policy and procedure including volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - a policy and procedure to address the use of volunteers during an emergency; - memorandums of agreement (MOAs) with other facilities; - a policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act for providing care and treatment at alternate care sites under a 1135 waiver; - a communication plan to include: - staff names and contact information - resident physician contact information - ombudsman and state licensing agency contact information - a method for sharing information and medical documentation for residents - sharing information regarding the licensee's occupancy, needs, and ability to provide assistance - a method for sharing information from the emergency plan with residents and their families; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills	0 680			

Minnesota Department of Health

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0 680	Continued From page 26 using the EPP. On March 4, 2026, at 9:15 a.m., LALD/CNS-A stated the licensee's EPP was reviewed annually by LALD/CNS-A and agent/owner (A/O)-G however documentation to support this was not completed. LALD/CNS-A further stated the licensee's missing resident policy was discussed with new staff at time of hire however there is no documentation supporting quarterly review as required. LALD/CNS-A stated LALD/CNS-A was not aware of the requirement to include memorandum of understanding with alternate care sites, resident population care needs, subsistence needs, and to address the 1135 waiver in the licensee's EPP. LALD-CNS-A shared that a resident/staff tracking form or process to document the movement of staff and residents was discussed but process not formalized, and form was not created. On March 4, 2026, at 9:51 a.m., LALD/CNS-A stated disaster drills were discussed with staff as part of orientation and during staff meetings however, the drills had not been implemented or documented yet. The licensee's Emergency Preparedness policy dated August 1, 2025, indicated [licensee] had an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy further indicated the licensee's EPP was prominently posted on each floor of the facility, was reviewed annually, and included conducting a disaster drill 'at least annually'. The licensee's Missing Resident policy dated August 1, 2025, indicated [licensee] immediately investigated any missing resident using an	0 680			

Minnesota Department of Health

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0 680	Continued From page 27 organized approach. The policy further indicated the missing resident procedure was reviewed by the director and CNS at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=D	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon	0 720			

Minnesota Department of Health

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0 720	Continued From page 28 request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner's authorized representative for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 3, 2026, at 7:43 a.m., the surveyor emailed the licensee the entrance email that indicated resident records must be available for review. On March 3, 2026, at 9:41 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's resident records were stored in a locked office for which the staff working had a key to access. LALD/CNS-A further stated R1's record was not currently available due to LALD/CNS-A having removed it from the house to work on completing documents from R1's recent admission. R1 was admitted on February 11, 2026, and began receiving assisted living services.	0 720			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
(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
0 720	Continued From page 29 On March 3, 2026, at 12:50 p.m., the surveyor requested R1's record from administrative assistant/unlicensed personnel (AA/ULP)-B. At 12:51 p.m., AA/ULP-B stated R1's record was not available due to LALD/CNS-A having brought it to LALD/CNS-A's office to complete admission documents. The licensee's Clinical Records policy dated August 1, 2025, indicated records were protected against loss, tampering or unauthorized disclosure and stored in a locked, secured location accessible to employees and contractors authorized to access the records. The policy further indicated clinical records were maintained in such a manner that allowed for timely access, printing, or transmission of the records. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
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.	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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0 775	Continued From page 30 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 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780			

Minnesota Department of Health

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0 780	Continued From page 31 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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0 780	Continued From page 32	0 780			
	TIME PERIOD FOR CORRECTION: Seven (7) days.				
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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0 790	Continued From page 33 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 800			

Minnesota Department of Health

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0 800	Continued From page 34 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 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810			

Minnesota Department of Health

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0 810	Continued From page 35 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			

Minnesota Department of Health

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0 830	Continued From page 36	0 830			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 830			

Minnesota Department of Health

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0 830	Continued From page 37	0 830			
	TIME PERIOD FOR CORRECTION: Seven (7) days.				
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and R2). This had the potential to affect the two residents who received assisted living services. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2026, at 9:21 a.m., licensed assisted living	0 910			

Minnesota Department of Health

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0 910	Continued From page 38 director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. R1 and R2's Assisted Living Contract were signed on February 11, 2026, and July 24, 2024, respectively. R1 and R2's assisted living contracts lacked the licensee's healthcare facility identification number (HFID). On March 4, 2026, at 2:11 p.m., LALD/CNS-A stated the same assisted living contract was used for all residents. LALD/CNS-A further stated LALD/CNS-A was aware the HFID was required to be on the contract however, LALD/CNS-A was unaware it was missing as the licensee purchased the contract template from a third-party consultant and believed the correct content was present at that time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract;	0 930			

Minnesota Department of Health

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0 930	Continued From page 39 (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with all required content for two of two residents (R1 and R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A state the licensee was familiar with current minimum assisted living requirements. R1 R1 was admitted on February 11, 2026, and began receiving assisted living services.	0 930			

Minnesota Department of Health

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0 930	Continued From page 40 R1's Service Plan dated February 11, 2026, indicated R1's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medication. R1's [licensee] Assisted Living Contract was signed on February 11, 2026. R2 R2 was admitted on July 24, 2024, and began receiving assisted living services. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's [licensee] Assisted Living Contract was signed on July 24, 2024. R1 and R2's assisted living contracts lacked addressing information regarding the resident's right to appeal termination of their assisted living contract. On March 4, 2026, at 2:11 p.m., LALD/CNS-A stated the same assisted living contract was used for all residents. LALD/CNS-A further stated the contract template was purchased from a third-party consultant and LALD/CNS-A assumed the required content was present at the time of purchase.	0 930			

Minnesota Department of Health

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0 930	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2026, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	0 970			

Minnesota Department of Health

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0 970	Continued From page 42 state the licensee was familiar with current minimum assisted living requirements. R1 R1 was admitted on February 11, 2026, and began receiving assisted living services. R1's Service Plan dated February 11, 2026, indicated R1's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medication. R1's [licensee] Assisted Living Contract was signed on February 11, 2026. R2 R2 was admitted on July 24, 2024, and began receiving assisted living services. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's [licensee] Assisted Living Contract was signed on July 24, 2024. The licensee's undated Assisted Living Contract, included the following clause that a resident would waive the facility's liability for health, safety, or personal property of the resident: - Page 12: Assignment: This Contract is not	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303		
(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
0 970	Continued From page 43 assignable by the resident without prior written consent of [licensee]. [licensee] may assign this Contract (sic) without the consent of the resident. In the event that [licensee] assigns this Contract (sic), the assignee will be responsible for all liabilities and obligations, which arise or accrue from and after the date of assignment, and the resident releases [licensee] from all such liabilities or obligations. On March 4, 2026, at 2:11 p.m., LALD/CNS-A stated the same assisted living contract was used for all residents. LALD/CNS-A further stated the contract template was purchased from a third-party consultant and LALD/CNS-A assumed the required content was present at the time of purchase and LALD/CNS-A is aware the licensee can't request a resident to release the licensee of liability for self and safety. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=F	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	01290			

Minnesota Department of Health

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01290	Continued From page 44 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 the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) for one of seven employees (administrative assistant/unlicensed personnel (AA/ULP)-B). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 March 3, 2026, at 9:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents in an employee record. AA/ULP-B was hired on July 23, 2025, and provided direct care services to residents. AA/ULP-B's employee record contained a background study with the HFID1092673 for a	01290			

Minnesota Department of Health

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01290	Continued From page 45 sister facility location and not the correct HFID 35571 for the licensee. On March 3, 2026, at 1:15 p.m., the surveyor observed AA/ULP-B inform R1 AA/ULP-B would provide transportation for R1 to the social security office after the health department survey was completed. On March 3, 2026, at 1:18 p.m., AA/ULP-B stated AA/ULP-B worked independently with residents of the licensee to assist with transportation to appointments and errands the residents requested. On March 4, 2026, at 3:10 p.m., LALD/CNS-A stated all background studies were completed by agent/owner (A/O)-G. LALD/CNS-A further stated LALD/CNS-A was aware all employees were required to have a cleared background study completed and affiliated to the correct HFID prior to working independently however, LALD/CNS-A did not have the access to complete that process for employees. The licensee's Recruitment and Hiring policy dated August 1, 2025, indicated the licensee completed a Minnesota Department of Human Services background study through NetStudy 2.0 (online background study platform) for all unlicensed employees and those licensed before January 1, 2018. The policy did not address background study affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01440	Continued From page 46	01440			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-D, ULP-E). 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	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01440	Continued From page 47 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: ULP-D was hired on December 4, 2025, and began providing assisted living services. ULP-E was hired on June 26, 2024, and began receiving assisted living services. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer oral medication to R2. R2's medication administration record dated March 1, 2026, indicated ULP-E administered oral medication to R2 on March 2, 2026, and ULP-D administered oral medication to R2 on March 2, 2026. ULP-D and ULP-E's employee records lacked a 30-day supervision for the delegated task of medication administration. On March 4, 2026, at 10:58 a.m., ULP-D stated licensed practical nurse (LPN)-F completed a 30-day supervision with them. ULP-D stated LPN-F was at the facility frequently and would watch them complete tasks and medication administration. Although ULP-D stated they received a 30-day supervision, the supervision was not completed by a registered nurse (RN). On March 4, 2026, at 11:57 a.m., the surveyor attempted to contact ULP-E via phone. The surveyor was not successful and was unable to	01440			

Minnesota Department of Health

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01440	Continued From page 48 leave a voicemail because the mailbox was full. On March 4, 2026, at 11:58 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated LPN-F assisted with medication training, competency evaluations, and 30-day supervisions because they worked at the facility more frequently. On March 4, 2026, at 2:40 p.m., LALD/CNS-A stated if an ULP was delegated medication administration "we" watch them do what "we" trained them to do. LALD/CNS-A stated they believed the 30-day supervisions were not filed by another employee. LALD/CNS-C stated they believed the other employee believed the certificate of completion related to medication administration was sufficient documentation for the employee record. The Nurse Practice Act - Minnesota Statutes Section 148.171 effective August 1, 2013, indicated the LPN's scope of practice included assigning and monitoring nursing tasks or activities to ULP and a RN scope of practice included managing, supervising, and evaluating the practice of nursing. The document indicated supervision of an ULP was not in their scope of practice. The licensee's Supervision : Unlicensed Staff policy dated August 1, 2025, indicated supervision of ULP performing medication or treatment administration shall be provided by the RN and include observation of the staff administering the medication or treatment and interacting with the resident. In addition, direct supervision of ULP who performed delegated tasks would be provided within 30 days after the individual begins working for the assisted living	01440			

Minnesota Department of Health

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01440	Continued From page 49 provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470			

Minnesota Department of Health

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01470	Continued From page 50 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an orientation which included all required content for three of three employees (unlicensed personnel (ULP)-C, ULP-D, ULP-E). 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	01470			

Minnesota Department of Health

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01470	Continued From page 51 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: ULP-C ULP-C was hired on August 21, 2020, under the licensee's previous comprehensive license and began providing assisted living services on August 1, 2021. ULP-C employee record included an Orientation check list completed August 20, 2020. The document indicated the orientation was completed for a comprehensive licensure. ULP-C's record lacked evidence that the following required orientation topics were conducted after August 1, 2021, when the new assisted living licensure went into effect: - overview of assisted living statutes; - assisted living bill of rights; and - review of the assisted living services the employee would provide and the providers scope of license. ULP-D ULP-D was hired on December 4, 2025, and began providing assisted living services. ULP-D's employee record included a form titled Staff Orientation Record dated December 6, 2025, and read "This program ensures competency in the following areas as required in the 245D HCBS [home and community-based services] Standards, section 245D.09." The document indicated the orientation was	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01470	Continued From page 52 completed by a different licensee under the same parent company however, it was completed for the incorrect license type of 245D. ULP-D's employee record lacked evidence of the following required orientation topics: - overview of assisted living statutes; - assisted living bill of rights; - consumer advocacy services; and - review of the assisted living services the employee would provide and the providers scope of license. ULP-E ULP-E was hired on June 26, 2024, and began receiving assisted living services. ULP-E's employee record included a form titled Staff Orientation Record dated June 30, 2024, and read "This program ensures competency in the following areas as required in the 245D HCBS [home and community-based services] Standards, section 245D.09." The document indicated the orientation was completed by a different licensee under the same parent company however, it was completed for the incorrect license type of 245D. ULP-E's employee record lacked evidence of the following required orientation topics: - overview of assisted living statutes; - assisted living bill of rights; - consumer advocacy services; and - review of the assisted living services the employee would provide and the providers scope of license. On March 4, 2026, at 2:41 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated general orientation was	01470			

Minnesota Department of Health

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01470	Continued From page 53 completed in person with use of a power point. LALD/CNS-A stated the licensee reviewed the power point and completed multiple quizzes on the topics. LALD/CNS-A stated the 245D orientation document listed above was a previous form the licensee used. LALD/CNS-A stated they believed the licensee continued to use the 245D form for orientation. When the surveyor inquired why the form was still being used for the licensee LALD/CNS-A was unable to explain why the form was still being used. In addition, LALD/CNS-A stated they did not know why the ULP files listed above did not include the required orientation topics. The licensee's Staff Orientation and Education policy Dated August 1, 2025, indicated all staff who provided assisted living services would be prepared to provide safe, effective services to all residents through a thorough orientation program pertinent to the needs of the residents. A repeat of orientation was not required if a staff member was transferring from one assisted living facility to another operated by the licensee or a licensed facility under the same organization. In addition, orientation topics would include the following: a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse,	01470			

Minnesota Department of Health

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01470	Continued From page 54 financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure k. The organizational chart and roles of staff within the facility". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01500	Continued From page 55 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01500	Continued From page 56 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment that included the required annual training content for two of two employees (unlicensed personnel (ULP)-C, ULP-E). 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: ULP-C ULP-C was hired on August 21, 2020, under the licensee's previous comprehensive license and began providing assisted living services on August 1, 2021. ULP-C employee record included a certificate of completion for the following: - two hour of infection control completed July 4,	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01500	Continued From page 57 2025; - two hour of medication administration completed July 4, 2025; - two hour of dementia training completed July 3, 2025; and - two hours competency skill test completed July 4, 2025. ULP-C record lacked the following required content: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; and - review of providers policies and procedures. ULP-E ULP-E was hired on June 26, 2024, and began receiving assisted living services. ULP-E record lacked eight hours of annual training for the year 2025. On March 4, 2026, at 2:43 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided eight hours of training to ULP yearly. LALD/CNS-C stated ULP complete annual training in person and then they update the certificate of completion. LALD/CNS-C stated ULP-C's record showed the content they trained on for annual training. The surveyor reviewed the required content needed for annual training. LALD/CNS-C stated they were unaware of the required content. LALD/CNS-C stated they believed ULP-E certificates of completion were miss filed. The licensee's Staff Orientation and Education policy dated August 1, 2025, indicated all staff providing assisted living services would complete at least eight hours of education for every 12 months of employment. The education topics	01500			

Minnesota Department of Health

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01500	Continued From page 58 would include, but not be limited to, the following: - reporting of maltreatment of adults; - review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the organizations policies and procedures related to the provision of assisted living services and how to implement them; - infection control techniques used in the facility; - two hours of dementia care training which included effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with the residents who have dementia, Alzheimer's disease or related disorders; - the principles of person centered planning and service delivery and how they apply to direct support services provided by staff; and - one hour of mental illness with de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01530	Continued From page 59 training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide two hours of initial training for employees hired prior to July 1, 2025, related to mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8) for two of two employees (unlicensed personnel (ULP)-C, ULP-E).	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01530	Continued From page 60 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: ULP-C ULP-C was hired on August 21, 2020, under the licensee's previous comprehensive license and began providing assisted living services on August 1, 2021. ULP-C employee record included one hour of mental health training completed August 23, 2020. ULP-C's employee record indicated ULP-C did not complete one of two initial hours for mental health training and lacked the required content of recognizing symptoms of common mental illness disease. ULP-E ULP-E was hired on June 26, 2024, and began receiving assisted living services. ULP-E record included one hour of mental health training completed on June 30, 2024. ULP-E's employee record indicated ULP-E did not complete one of two initial hours for mental health training and lacked the required content of recognizing symptoms of common mental illness disease. On March 4, 2026, at 2:43 p.m., licensed assisted living director/clinical nurse supervisor	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01530	Continued From page 61 (LALD/CNS)-A stated the licensee reviewed a power point for mental health training. The surveyor inquired how long the training was. LALD/CNS-A stated they did not know how long the mental health training was. The surveyor inquired if they were familiar with the required mental health content. LALD/CNS-A stated they were not aware of the required mental health training content. LALD/CNS-A stated ULP-C's employee record was composed by them and would include the information the licensee trained employees on. The Staff Orientation and Education policy dated August 1, 2025, indicated direct care staff and supervisor must receive training on mental illness with de-escalation during orientation. In addition, annual training included one hour of mental illness with de- escalation. The policy did not address the initial mental illness and escalation hours or topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01620			

Minnesota Department of Health

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01620	Continued From page 62 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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.	01620			

Minnesota Department of Health

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01620	Continued From page 63 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 comprehensive assessments within 14 days following a residents admission date for one of two residents (R1). In addition, the licensee failed to ensure the RN conducted comprehensive assessments following the uniform assessment tool (UAT) that included all required content for two of two residents (R1 and R2). The licensee also failed to ensure ongoing comprehensive assessments not to exceed 90-days were completed for one of two residents (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 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 March 3, 2026, at 9:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated upon admission of a resident, the licensee completed a nursing assessment on the day of admission, within 14 days after admission, and every 90 days. R1 R1 was admitted on February 11, 2026, and began receiving assisted living services.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01620	Continued From page 64 R1's diagnoses included schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior), anxiety, and depression. R1's Service Plan dated February 11, 2026, indicated R1's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medication. R1's Admission Assessment dated February 12, 2026, included the UAT content and was completed by LALD/CNS-A. R1's [licensee] Nurse Reassessment Visit (14-day assessment) dated February 20, 2026, was completed by LALD/CNS-A however, lacked addressing the following content from the UAT: - sleep schedule; - social needs and leisure activities of interest; - spiritual and cultural preferences; - activities of daily living; - housekeeping and laundry; - transportation; - allergies; - review of medications including the reason taken, side effects/contraindications, dosage, frequency, route administered, any difficulties taking medication, preference of how to take medication, intervention to prevent diversion, and instructions to resident/family for medication management to prevent diversion; - review medical, dental, and emergency room visits within the last 12 months; - weight;	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01620	Continued From page 65 - communication including hearing, vision, and speech; and - smoking safety; and - decision-making authority for the resident. R1's record lacked a 14-day comprehensive nursing assessment completed by an RN that included required content from the UAT. R2 R2 was admitted on July 24, 2024, and began receiving assisted living services. R2's diagnoses included schizophrenia and anxiety. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's [licensee] Nurse Reassessment Visit (90-day assessment) dated July 28, 2025, and October 13, 2025, respectively, were completed and authenticated by licensed practical nurse (LPN)-F and lacked addressing the following content from the UAT: - sleep schedule; - social needs and leisure activities of interest; - spiritual and cultural preferences; - activities of daily living; - housekeeping and laundry; - transportation; - allergies; - review of medications including the reason taken, side effects/contraindications, dosage, frequency, route administered, any difficulties	01620			

Minnesota Department of Health

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01620	Continued From page 66 taking medication, preference of how to take medication, intervention to prevent diversion, and instructions to resident/family for medication management to prevent diversion; - communication including hearing, vision, and speech; and - smoking safety; and - decision-making authority for the resident. R2's [licensee] Nurse Reassessment Visit (90-day assessment) dated January 26, 2026, was completed and authenticated by licensed practical nurse (LPN)-F and lacked addressing the above mentioned content from the UAT and indicated 105 days had passed since R2's last 90-day assessment. R2's record lacked 90-day comprehensive nursing assessments completed by an RN which included the required content from the UAT and were completed within the required time frame. On March 4, 2026, at 3:13 p.m., LALD/CNS-A stated LALD/CNS-A was unaware the 14-day and 90-day assessment forms were missing required content. LALD/CNS-A further stated LALD/CNS-A was aware comprehensive nursing assessments needed to be completed by an RN however believed LPN-F was able to complete them due to understanding the format that the licensee utilized was sufficient. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2025, indicated an RN conducted comprehensive nursing assessments utilizing required content in the UAT. The licensee's Assessment and Reassessment policy dated August 1, 2025, indicated an RN	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01620	Continued From page 67 provided a reassessment visit to update the evaluation of resident needs and services no more than 14 days after initiation of services. The policy further indicated ongoing resident reassessments must be conducted by an RN and could not exceed 90 days from the last date of assessment. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01710	Continued From page 68 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual re-assessments for an individualized medication management plan (IMMP) for one of two residents (R2) who received medication management services for longer than one year. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 March 3, 2026, at 9:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. R2 was admitted on July 24, 2024, and began receiving assisted living services.	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01710	Continued From page 69 R2's diagnoses included schizophrenia and anxiety. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. R2's Medication Management Plan dated July 24, 2024, was identified by LALD/CNS-A as R2's most recent individual medication management plan (IMMP) assessment. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's record lacked evidence of annual assessment and completion of an IMMP. On March 4, 2026, at 3:17 p.m., LALD/CNS-A stated LALD/CNS-A was aware of the requirement to complete resident medication management assessment and plan annually and was unsure why R2's was not completed in 2025. The licensee's Assessment of Medications policy indicated a resident's IMMP was evaluated/updated as needed with changes in medications. The policy further indicated medication reassessment occurred if a resident showed a change in symptoms, there were problems or concerns related to medications, new prescriptions received, and annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
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01750	Continued From page 70	01750			
01750 SS=I	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 observation, interview, and record review, the licensee failed to ensure, prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and failed to ensure the RN evaluated the ULPs' ability to competently perform the task for two of two employees (ULP-E, ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems 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: R2's medication administration record (MAR)	01750	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		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER ACCESS MINNESOTA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 335 37TH AVENUE NORTH SAINT CLOUD, MN 56303			
(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
01750	Continued From page 71 dated March 1, 2026, through March 31, 2026, indicated ULP-E administered oral medication on March 1, 2026. In addition, R2's MAR indicated ULP-D administered oral medication to R2 on March 2, 2026, and March 3, 2026. ULP-E ULP-E was hired on June 26, 2024, to provide assisted living services. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E obtain R2's medications from the locked medication file cabinet. The surveyor observed ULP-E ask R2 what their last name was. ULP-E dispensed bupropion extended release 150 milligrams (mg), aripiprazole 15 mg, vitamin D 25 micrograms (mcg), and tetrabenazine 12.5 mg into a medication cup without verifying medications against a MAR. ULP-E administered the medications listed above to R2. The surveyor then observed ULP-C remove the MAR from a cabinet and document on the medication listed above that ULP-E administered to R2. At 7:34 a.m., ULP-E stated they worked the overnight shift, and they were assisting the day shift with the medications, but they did not document because it was not their shift. ULP-E's personnel record included a document titled Staff Orientation Record signed on June 30, 2024. The document indicated it was an orientation from a 245D agency (entity licensed by the Department of Health and Human Services), operated by the same parent company as the licensee. The document read, "Observed medication administration skill assessment completed". It indicated the task was completed on June 30, 2024, took one hour, and was completed by agent/owner (A/O)-G. ULP-E's	01750	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.		

Minnesota Department of Health

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01750	Continued From page 72 record lacked a competency evaluation completed by the licensee's RN. ULP-D ULP-D was hired on December 4, 2025, to provide assisted living services. ULP-D's personnel record included a document titled Staff Orientation Record signed on December 6, 2025. The document indicated it was an orientation from a 245D agency, operated by the same parent company as the licensee. The document read, "Observed medication administration skill assessment completed. It indicated the task was completed on December 3, 2025, by administrative assistant/unlicensed personnel (AA/ULP)-F and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. On March 4, 2026, at 10:58 a.m., ULP-D stated licensed practical nurse (LPN)-F trained them and completed a competency evaluation for medication administration with them prior to them independently administering medications. On March 4, 2026, at 11:57 a.m., the surveyor attempted to contact ULP-E via phone. The surveyor was not successful and was unable to leave a voicemail because the mailbox was full. On March 4, 2026, at 11:58 a.m., LALD/CNS-A stated staff were trained for medication administration by use of PowerPoint, then ULP completed a medication post-test on paper, followed by completing a medication competency evaluation. LALD/CNS-A stated the medication administration competency would be documented on a form titled Home Health Aide Medication Competency Evaluation. LALD/CNS-A stated	01750			

Minnesota Department of Health

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01750	Continued From page 73 once the competency evaluation was complete, they would receive a certificate of completion for medication administration. LALD/CNS-A stated LPN-F and themselves completed the medication training and competencies for ULP. LALD/CNS-C stated they would conduct the initial training for medication and if a person needed to re-do the competency evaluation or needed more training, LPN-F would complete it because they were in the facility more frequently than they were. On March 4, 2026, at 1:59 a.m., LALD/CNS-A stated they trained ULP-D for medication administration for two days. LALD/CNS-A stated that after medication administration training was completed LPN-F reviewed medication administration and would have completed the competency evaluation. The licensee's Medication Administration policy dated August 1, 2025, indicated the RN may delegate medication administration to an ULP according to the following protocol: - all ULP have passed a competency evaluation with respect to all medication routes to be administered; - the RN had prepared written instructions for the ULP in the proper methods to administer medication with respect to each resident; and - the RN has communicated with or provided orientation to the ULP related to the individual need of the resident. The licensee's Personnel Records policy dated August 1, 2025, indicated personnel records would include competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			

Minnesota Department of Health

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of the administration of medications included all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 March 3, 2026, at 9:27 a.m., licensed assisted living	01760			

Minnesota Department of Health

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01760	Continued From page 75 director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to resident. R2 was admitted on July 24, 2024, and began receiving assisted living services. R2's diagnoses included schizophrenia and anxiety. R2's Service Plan dated July 24, 2024, indicated R2's services included medication management, grooming cueing, meals, and monthly vital signs. R2's Medication Management Plan dated July 24, 2024, indicated R2 received medication administration daily. On March 4, 2026, at 7:32 a.m., the surveyor observed ULP-E administer R2's scheduled morning medication. R2's medication administration record (MAR) dated February 1 through February 28, 2026, indicated R2 was prescribed tetrabenazine (manages involuntary, jerky movements) 12.5 milligrams (mg) two times daily. Review of R2's February MAR lacked documentation on February 27, 2026, and February 28, 2026, which indicated whether R2 received the medication or refused the medication and why. On March 4, 2026, at 3:23 p.m., LALD/CNS-A stated the unlicensed personnel had likely forgotten to complete medication documentation for R2 on February 27, 2026, and February 28, 2026. LALD/CNS-A further stated when cycle fill of medication is delivered for each month, a nurse completed medication supply and MAR audits for the prior month to assess for refused or	01760			

Minnesota Department of Health

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01760	Continued From page 76 missed doses of which there were none for R2. LALD/CNS-A acknowledged however, if documentation is not completed, it would appear something was not done. The licensee's Medication Documentation policy dated August 1, 2025, indicated each medication administered by [licensee] staff was documented in the resident's clinical record and included the signature and title of the staff who administered the medication. The policy further indicated when administration of medication was not completed, staff documented the reason why the medication was not administered, follow-up procedures to meet the resident's needs in compliance with the medication management plan, notification to RN (registered nurse) supervisor regarding missed dosages, and completion of a medication error report if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	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; (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	01790			

Minnesota Department of Health

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01790	Continued From page 77 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 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	01790			

Minnesota Department of Health

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01790	Continued From page 78 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) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for three of three employees (unlicensed personnel (ULP)-C, ULP-D, ULP-E). 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: ULP-C was hired on August 21, 2020, under the licensee's previous comprehensive license and began providing assisted living services on August 1, 2021. ULP-D was hired on December 4, 2025, and began providing assisted living services. ULP-E was hired on June 26, 2024, and began	01790			

Minnesota Department of Health

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01790	Continued From page 79 receiving assisted living services. ULP-C, ULP-D, and ULP-E's employee record lacked training and a return demonstration competency evaluation for unplanned time away from home. On March 4, 2026, at 10:58 a.m., ULP-D stated they were trained on unplanned time away at a different license the parent company owned. ULP-D stated they were trained for unplanned time away from home from licensed practical nurse (LPN)-F and administrative assistant/unlicensed personnel (AA/ULP)-B. ULP-D stated they completed a return demonstration with one of the experienced employees. Although ULP-D received training and had completed a return demonstration to another employee, ULP-D did not have a competency evaluation completed by a RN. On March 4, 2026, at 11:57 a.m., the surveyor attempted to contact ULP-E via phone. The surveyor was not successful and was unable to leave a voicemail because the mailbox was full. On March 4, 2026, at 2:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were trained to fill out a form and have the resident sign the form when they leave the facility with medications. LALD/CNS-A stated the licensee did not document training or competency evaluations for unplanned time away from home. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2025, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the	01790			

Minnesota Department of Health

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01790	Continued From page 80 pharmacy or set up by the RN in a timely manner, the RN may delegate to a ULP to provide the medication if the RN had trained the ULP and determined the ULP competent to follow procedures for providing medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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 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	01910			

Minnesota Department of Health

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01910	Continued From page 81 record all required content for disposition of medications for one of two resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 March 3, 2026, at 9:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. The licensee's Discharged or Deceased Client Roster dated March 4, 2026, indicated R3 was admitted to the facility on August 20, 2020, and discharged on November 12, 2025. R3's Active Medications at Discharge dated November 12, 2025, lacked a prescription number and quantity of each medication remaining as well as authentication from the resident or party who received the medications at discharge. On March 4, 2026, at 1:31 p.m., LALD/CNS-A stated LALD/CNS-A was aware of the required content for medication disposition documentation and LALD/CNS-A was unsure why the information was not included. LALD/CNS-A further stated R3	01910			

Minnesota Department of Health

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01910	Continued From page 82 refused to sign the disposition of medication form however that was not noted on the form or in the discharge note in R3's record. The licensee's Disposition and Disposal of Medications policy dated August 1, 2025, indicated upon disposition of medications previously managed by [licensee], the following information was documented in the resident's clinical record: -name, strength, and prescription number of medication; -quantity; -method of disposition or to whom the medications were given; -date of disposition; -name/signature of staff involved in the disposition; and -to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Access Minnesota LLC
335 37th Avenue North
St Cloud, MN 56303
Stearns County
Parcel:

Phone:

License Info

License: HFID 35571

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

Inspection Info

Report Number: F1046261052
Inspection Type: Full - Single
Date: 3/3/2026 Time: 11:30:40 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 3
Total Priority 3 Orders: 6
Delivery:

New Order: 2-100 Supervision

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

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: SEND ONE FULL TIME EMPLOYEE TO A FOOD SAFETY COURSE AND APPLY FOR STATE CERTIFICATE WITHIN 6 MONTHS OF PASSING A FOOD SAFETY COURSE.

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

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: POST THE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE ONCE OBTAINED.

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

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: OBSERVED A BIN OF BULK SUGAR WITH NO LABEL. PROVIDE A LABEL INDICATING CONTENTS.

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

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

3-304.12A Priority Level: Priority 3 CFP#: 43

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

COMMENT: OBSERVED A COFFEE MUG BEING USED AS A SCOOP IN THE RICE BIN. USE A SCOOP WITH A LONG HANDLE AND STORE THE HANDLE UP AND OUT OF THE FOOD, OR IN A CLEAN AND PROTECTED LOCATION.

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

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A1 Priority Level: Priority 1 CFP#: 21

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roast beef may be held at 130 degrees F (54 degrees C) if cooked in accordance with the specified time and temperature.

COMMENT: OBSERVED COOKED FISH IN AN AIR FRYER HELD AT 115. TCS FOOD ITEMS MUST BE HOT HELD AT 135 OR ABOVE.

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

! New Order: 3-500B Microbial Control: hot and cold holding3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: FOOD ITEMS IN THE UPRIGHT COOLER MEASURED: NOODLE (44), COOKED BEANS (44). ADJUST COOLER TO MAINTAIN FOOD TEMPERATURES AT 41 OR BELOW.

*Comply By: 3/3/2026 Originally Issued On: 3/3/2026***New Order: 3-500C Microbial Control: date marking**3-501.17A *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

COMMENT: NO PREPARED FOOD ITEMS IN THE UPRIGHT COOLER HAD DATES ON THEM. DEVELOP AND EFFECTIVE DATE MARKING SYSTEM AND DATE ALL PREPARED OR OPENED TCS FOOD ITEMS.

*Comply By: 3/3/2026 Originally Issued On: 3/3/2026***! New Order: 3-700 Contaminated Food: discarded**3-701.11A *Priority Level: Priority 1 CFP#: 17*

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

COMMENT: 1) DISCARD IMPROPERLY COLD HELD FOODS: NOODLE (44), COOKED BEANS (44).

2) DISCARD PREPARED FOOD WITH NO DATES: NOODLE, COOKED BEANS, CHICKEN PASTA.

3) DISCARD IMPROPERLY HOT HELD FOOD: FISH (115).

*Comply By: Complied On Site Originally Issued On: 3/3/2026***New Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36*

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: PROVIDE A THERMOMETER IN THE WARMEST PART OF THE UPRIGHT COOLER.

*Comply By: 3/10/2026 Originally Issued On: 3/3/2026***New Order: 4-300 Equipment Numbers and Capacities**4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: PROVIDE A THIN-TIP THERMOMETER FOR TAKING TEMPERATURES OF FOOD ITEMS.

*Comply By: 3/10/2026 Originally Issued On: 3/3/2026***New Order: 4-300 Equipment Numbers and Capacities**4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: ESTABLISHMENT USES QUAT SANITIZER, OBTAIN QUAT TEST STRIPS.

*Comply By: 3/10/2026 Originally Issued On: 3/3/2026***New Order: 4-500 Equipment Maintenance and Operation**4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: 1) ADJUST UPRIGHT COOLER TO MAINTAIN FOOD ITEMS AT 41 OR BELOW.

2) DISHWASHER FINAL RINSE TEMP DID NOT MEET 160F REQUIREMENT. REPAIR DISHWASHER TO ENSURE FINAL RINSE DISH SURFACE TEMP REACHES 160F.

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

! New Order: 4-700 Sanitizing Equipment and Utensils

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

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

COMMENT: DISHWASHER FINAL RINSE SURFACE DISH TEMP DID NOT REACH 160F. ENSURE DISHWASHER FINAL RINSE SURFACE DISH TEMP ACHIEVES 160F OR MORE.

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

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

I acknowledge receipt of the St Cloud District Office inspection report number F1046261052 from 3/3/2026

Establishment Representative



Nicole Larrison,
Public Health Sanitarian 1
320-640-3534
nicole.larrison@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Access Minnesota LLC
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046261052
Inspection Type: Full
Date: 3/3/2026
Time: 11:30:40 AM

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

Location: Upright Cooler at 44 Degrees F.

Comment: NO DATE

Violation Issued?: Yes

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

Location: Upright Cooler at 44 Degrees F.

Comment: NO DATE

Violation Issued?: Yes

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

Location: Upright Cooler at 41 Degrees F.

Comment: NO DATE

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** COOKED FISH; **Temperature Process:** Hot-Holding

Location: AIR FRYER at 115 Degrees F.

Comment:

Violation Issued?: Yes



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Access Minnesota LLC
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046261052
Inspection Type: Full
Date: 3/3/2026
Time: 11:30:40 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Less Than** 150 Degrees F.

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Pre-Soaked Towelettes

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1046261052		Food Establishment Inspection Report		Page 1 of 1				
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		6	Date: 3/3/2026			
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:30:40 AM			
		Score (optional)			Dur: min			
Establishment: Access Minnesota LLC		Address: 335 37th Avenue North		City/State: St Cloud, MN	Zip: 56303	Phone:		
License/Permit #: HFID 35571		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS								
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status				COS	R			
Supervision								
1	IN	Person in charge present, demonstrate knowledge and performs duties						
2	OUT	Certified Food Protection Manager						
Employee Health								
3	IN	knowledge, responsibilities, and reporting						
4	IN	Proper use of restriction and exclusion						
5	IN	Response to vomiting, diarrheal events						
Good Hygienic Practices								
6	IN	Proper eating, tasting, drinking, tobacco use						
7	IN	No discharge from eyes, nose, and mouth						
Preventing Contamination by Hands								
8	IN	Hands clean and properly washed						
9	IN	No bare hand contact with RTE foods, alternatives						
10	IN	Adequate handwashing sinks supplied and access						
Approved Source								
11	IN	Food obtained from approved source						
12	N/O	Food Received at proper temperature						
13	IN	Food in good condition, safe & unadulterated						
14	N/A	Records available: shellstock tags, parasite dest.						
Protection From Contamination								
15	IN	Food separated and protected						
16	OUT	Food-contact surfaces; cleaned & sanitized						
17	OUT	Proper Disposition of returned, previously served, reconditioned, & unsafe food	X					
GOOD RETAIL PRACTICES								
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.								
Mark "X" or OUT in box if numbered item is not in compliance				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
COS				R				
Safe Food and Water								
30	N/A	Pasteurized eggs used where required						
31		Water & ice from approved source						
32	N/A	Variance obtained for specialized processing methods						
Food Temperature Control								
33		Proper cooling methods used; adequate equipment for temperature control						
34	N/O	Plant food properly cooked for hot holding						
35	N/O	Approved thawing methods used						
36	X	Thermometers provided & accurate						
Food Identification								
37	X	Food properly labeled; original container						
Prevention of Food Contamination								
38		Insects, rodents, & animals not present; no unauthorized person						
39		Contamination prevented during food prep, storage, & display						
40		Personal cleanliness						
41		Wiping cloths: properly used & stored						
42		Washing fruits & vegetables						
Person in Charge (signature)								
Inspector (signature)				Follow-up: Follow-up Date:				

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35571016	Date: 3/3/2026
Facility Name: Access Minnesota LLC	
Facility Address: 335 37 th Ave. St. Cloud, MN 56303	

☒ 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: Unit 335- Bedroom 2 and 5 the egress window would not open. Unit 337- Office 4 and 5 the egress window would not open.

3. Lighted matches, cigarettes, cigars or other burning object 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: A cigarette butt receptacle was provided outside of unit 335 but it was found that cigarette butts were lying on the ground by the building and front steps.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: Bedrooms 1, 2, 3, 4, and 5 were either missing the smoke alarm or if it had one, it was not working.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: There was not a working smoke alarm provided outside of bedrooms 1, 2, 3, 4 and 5.

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

Comments: The smoke alarms in unit 337 were not working.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: There was no fire extinguisher provided in unit 337. Unit 335 had a fire extinguisher, but the annual inspection was done in February 2025 and there was no documentation for monthly inspections done by staff.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) 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: Unit 335- bedroom# 3 had stains on the window track. This window was hard to open. There were stains on the ceiling, and the wall by the bed had the finishes coming off. The ceiling vent was full of lint and debris. There was a large dark stain on the ceiling in the hallway above the bathroom door. Bedroom #4 window screen was coming off. The windowsill had mold. The utility room wall had a black stain by the furnace. Bedroom #5 had the closet door off. The basement bathroom vanity had the finishes coming off and the doors would not shut properly. Main floor Bathroom ceiling had the finishes coming off and the ceiling fan had dust and lint buildup. No outlet cover on the plug in the dining room.

Unit 337- Office#1 had stains on the ceiling. Office #2 had mold on the windowsill. Office #5 had black mold on and under the windowsill. Closet doors were missing in offices 1, 2, 3, 4, and 5. Bathroom (Main floor) vanity had the finishes coming off and the vanity door coming off. Bathroom shower/tub was stained and soiled. Bathroom in the basement was missing the drawer handles and finishes on the vanity.

The vanity doors had fallen off. The wall return vent had dust and debris built up. Office # 3 had the carpet coming up. Office #4 had the screen coming off. The kitchen exhaust hood was missing the control knobs and vent screen. The island cabinet had drawers coming off and the cabinet doors would not close properly. Finishes were coming off. The wooden cabinet finishes were in tough shape, there was lots of staining and delaminating. Doors on the cabinets did not close properly.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee had an emergency evacuation map hanging on the wall on the main floor but did not provide one for the basement. The evac map on the wall on the main floor was not the correct layout for unit 335 and was the floor plan for unit 337. Unit. There was no Emergency evacuation map provided in unit 337.

2. 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 that was provided used the R.A.C.E acronym and was deficient on what actions employee take in the event of a fire or similar emergency.

3. 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 that was provided used the RACE acronym and was generic. There was no specific details on procedures for residents to take in the event of a fire or similar emergency.

4. 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 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 current FSEP did not have specific procedures for the resident movement, evacuation and relocation.

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

Comments: administrative assistant/unlicensed personnel (AA/ULP)-B stated that they have been doing fire safety and evacuation training as required for the employees but did not provide the documentation.

6. Residents who are capable of assisting in their own evacuation shall be trained in the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: AA/ULP-B stated that the residents did receive training on the steps to take in the event of an evacuation, but they did not provide any documentation.

7. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: AA/ULP-B stated that employees have been doing evacuation drills every other month, but they were unable to provide any documentation.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

Comments: On March 3, 2026, it was discovered that unit 337 was empty, and minor renovations had been made such as a new kitchen countertop and new dining and kitchen flooring. No floor plan was provided to identify the intended use of this unit and its rooms. AA/ULP-B stated that the owner does not plan to house any residents in this unit and that this space will be kept empty with the possibility of using it for office space someday. Unit 337 had been purchased by the owner, and he submitted an application for plan review on October 16, 2023. A plan review inspection was done on June 24, 2024, and an inspection letter was sent out to the owner on July 29, 2024, to which there was no response.