Electronically Delivered

September 16, 2025

Licensee
Summerwood of Plymouth
16205 36th Avenue North
Plymouth, MN 55446

RE: Project Number(s) SL30236016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
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

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,

Jess schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30236	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

(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: SL30236016-0 On July 28, 2025, through July 30, 2025, 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 123 residents; 51 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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 the employee record contained the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 650		

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0 650	Continued From page 2 The findings include: ULP-C was hired on January 4, 2024, and began providing assisted living services. ULP-C's employee file lacked documentation of an annual performance review to include identified areas of improvement needed and training needs. On July 30, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated ULP-C's employee record lacked an annual performance review and stated it had not been completed. On July 30, 2025, at approximately 1:00 p.m., CNS-B provided surveyor with a document dated July 1, 2025, indicating the contents of employee records. The document indicated all original performance evaluations or corrective actions must be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;	0 730		

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0 730	Continued From page 3 (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of a written discharge summary for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on July 15, 2024, and discharged on December 23, 2024, to a hospice facility. R2's medical record lacked a written discharge summary, including service termination notice and related documentation, when applicable. On July 29, 2025, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated R2's record lacked documentation of a discharge summary. CNS-B stated the discharge summary had not been completed. The licensee's MN AL Resident Record policy dated March 16, 2024, indicated resident records would include a discharge summary, including service termination notice and related documentation when applicable. No further information was provided.	0 730		

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0 730	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide the required drills. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. The documentation provided on the fire drill reports had the drill description as "verbal education". The section of the drill report that discussed the number of residents evacuated either simulated or actual was marked as "N/A". In the critique area of the drill report described the discussion of R.A.C.E., shelter in place, P.A.S.S., smoke compartments, and fire doors. There was also a second page to the drill documentation	0 810		

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0 810	Continued From page 7 titled "Fire drill procedure review" that covered topics discussed in the FSEP. During interview LALD-A agreed that the drill documentation did not support drills, but did support training. LALD-A stated that they understood the deficient condition and would take necessary steps to correct the lack of drill documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440		

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01440	Continued From page 8 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated task for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of employees are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on April 14, 2025, and began providing assisted living services. R5 was admitted on April 2, 2025, and began receiving assisted living services. R5's record included a Service Plan dated May 15, 2025, indicating R5's services included medication administration. R5's record included a Medication Administration Summary dated July 2025, indicating ULP-D had administered medication to R5 on July 10, 11, 13, 18, 21, and 26, 2025. ULP-D's employee record included a Resident Assistant Competency Review dated May 15,	01440		

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01440	Continued From page 9 2025, and authenticated by a registered nurse. ULP-D's competency review was not completed, indicating ULP-D had not demonstrated competency on delegated tasks. On July 30, 2025, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated ULP-D's 30-day supervisory review was not completed. CNS-B stated they would ensure the supervision was complete. The licensee's MN AL Delegation and Supervision policy dated August 9, 2022, indicated supervision of resident assistants by a registered nurse will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	01620		

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01620	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 11 licensee failed to ensure the registered nurse (RN) conducted a reassessment no more than 14 days after initiation of services for one of four 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of employees are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted July 15, 2024, and began receiving assisted living services. R2's Service Plan signed on July 12, 2024, indicated R2's services included bathing assistance. R2's record included an initial nursing assessment completed on July 24, 2024, and a 90-day assessment completed on October 31, 2024. R2's record lacked a 14-day assessment completed by a RN. R2's record included a 14-day assessment on January 14, 2025, and a 90-day assessment on May 18, 2025, indicating 124 days had passed between consecutive assessments. On July 29, 2025, at 2:50 p.m., clinical nurse supervisor stated R2's 14-day assessment was not completed. CNS-B stated the assessment was not done due to a transition of nursing staff at the time the assessment was due.	01620		

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01620	Continued From page 12 The licensee's MN AL Nursing Assessment policy dated May 3, 2022, indicated an assessment would be completed up to 14 days after start of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01640		

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	30236	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

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01640	Continued From page 13 review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on June 29, 2023, and began receiving assisted living services. R4's record included a Service Plan dated October 1, 2023, indicating R4's services included bathing, toileting and meal assistance, linen changes, laundry, and problem-solving assistance. R4's record included a Service Recap Summary dated July 2025, indicating R4 received services for medication administration, repositioning and transfers, oxygen management, and vital sign monitoring. R4's service plan lacked revision to reflect the current services provided including medication management, oxygen management, bed mobility and transfer assistance, and vital sign monitoring. On July 29, 2025, at 7:50 a.m., the surveyor observed R4 receiving oxygen by nasal cannula. On July 29, 2025, at 2:52 p.m., clinical nurse	01640		

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01640	Continued From page 14 supervisor (CNS)-B stated R4 was receiving services not identified in the current service plan and that the current service plan had not been updated since October 1, 2023. CNS-B stated the service plan would be revised and R4's representative notified of changes to the plan. The licensee's MN AL Service Plan policy dated August 1, 2021, indicated service plans would be reviewed and revised as needed based upon ongoing resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 15 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a patterned scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R2 R2 was admitted July 15, 2024, and began receiving assisted living services. R2's record included a Service Plan signed on July 12, 2024, indicating R2's services included assistance with bathing. R3 R3 was admitted on February 17, 2025, and	01650		

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01650	Continued From page 16 began receiving assisted living services. R3's record included a Service Plan signed on February 13, 2025, indicating R3's services included medication administration, blood glucose checks, mealtime assistance, bathing assistance, and vital sign monitoring. R2 and R3's Service Plans lacked documentation of the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition. On July 29, 2025, at 2:52 p.m., clinical nurse supervisor (CNS)-B stated R2 and R3's service plans were missing emergency contact information for the residents. CNS-B stated the admissions were done "in a hurry" and the information was missed. The licensee's MN AL Service Plan policy dated August 1, 2021, indicated service plans would include the names and contact information of persons the resident wishes to have notified in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional,	01700		

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01700	Continued From page 17 or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a medication management assessment which included all content prior to providing medication management services for two of three residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a patterned scope (when more than a limited number of residents are affected,	01700		

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01700	Continued From page 18 more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R3 R3 was admitted on February 17, 2025, and began receiving assisted living services. R3's record included a Service Plan signed on February 13, 2025, indicating R3's services included medication administration. R3's record included a Medication Administration Record dated July 2025, indicating medications that had been administered to R3 included amlodipine (to treat high blood pressure), cholecalciferol (a vitamin supplement), magnesium oxide (a mineral supplement), metformin (to treat diabetes), omeprazole (for gastric reflux), Preservision AREDS (for eye health), Vitamin C (a vitamin supplement), tamsulosin (for prostate), simvastatin (for high cholesterol), L-arginine (for wound healing), and insulin (for diabetes). R3's medication assessment completed on July 8, 2025, by a RN, lacked identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R5 R5 was admitted on April 2, 2025, and began receiving assisted living services. R5's record included a Service Plan signed on April 19, 2025, indicated R5's services included	01700		

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01700	Continued From page 19 medication administration. R5's record included a Medication Administration Record dated July 2025, indicating medications that had been administered to R5 included acetaminophen (for back pain), amlodipine (for blood pressure), aspirin (for heart health), cholecalciferol (vitamin supplement), donepezil (for depression), memantine (for memory loss), metformin (for diabetes), tamsulosin (for bladder health), and mirtazapine (for depression). R5's's medication assessment completed by an RN on May 15, 2025, lacked identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On July 29, 2025, at 2:02 p.m., clinical nursing supervisor (CNS)-B stated they were unaware the medication assessments were lacking required content. CNS-B stated they would provide additional training to the nurses completing the assessments. The licensee's AL Medication Management policy dated September 19, 2024, indicated a registered nurse would conduct a face-to-face assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion, or other concerns. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

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01700	Continued From page 20 days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730		

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01730	Continued From page 21 reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with all required content for three of three residents (R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 R3 was admitted on February 17, 2025, and began receiving assisted living services. R3's record included a Service Plan signed on February 13, 2025, indicating R3's services included medication administration. R3's Individualized Medication Management Plan, dated July 8, 2025, lacking the following required content:	01730		

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01730	Continued From page 22 -identification of medication management tasks that may be delegated to unlicensed personnel; and -procedures for staff notifying a registered nurse or appropriate licensed personnel when a problem arises with medication management services. R4 R4 was admitted June 29, 2023, and began receiving assisted living services. R4's Medication Administration Summary dated July 2025, indicating R4 was administered the following medications during the month of July 2025: -acetaminophen 500 milligrams (mg), take two tablets by mouth (po) twice daily for pain; and -quetiapine 25 mg, take one tablet po at bedtime. R4's Individual Medication Management Plan dated July 11, 2025, lacked identification of medication management tasks that may be delegated to unlicensed personnel. R5 R5 was admitted on April 2, 2025, and began receiving assisted living services. R5's record included a Service Plan signed on April 19, 2025, indicating R5's services included medication administration. R5's Individualized Medication Management Plan dated May 15, 2025, lacked identification of medication management tasks that may be delegated to unlicensed personnel. On July 29, 2025, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the	01730		

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01730	Continued From page 23 medication management plans lacked required content. CNS-B stated they had not recently reviewed a medication management plan as other registered nurses completed them. The licensee's AL Medication Management policy revised on September 19, 2024, indicated a medication management plan would be developed following a face-to-face assessment to determine resident's need for medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	02170		

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02170	Continued From page 24 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan for three of three residents who resided in an assisted living with dementia care facility (R3, R4, R5) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 with dementia care (ALFDC) license issued on December 1, 2024, through November 30, 2025.	02170		

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02170	Continued From page 25 During the entrance conference on July 28, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R3 R3 was admitted on February 13, 2025, with a diagnosis of dementia and resided in the secured dementia care unit. R3's record included an Individualized Activity Plan dated April 11, 2025, which included an evaluation of the activity areas required under Minnesota Statute 144G.84. R3's record did not include an individualized activity plan with a daily selection of structured and non-structured activities specific for R3. R4 R4 was admitted on October 1, 2023, with a diagnosis of Alzheimer's disease and resided in the secured dementia care unit. R4's record included an Individualized Activity Plan dated July 11, 2025, which included an evaluation of the activity areas required under Minnesota Statute 144G.84. R4's record did not include an individualized activity plan with a daily selection of structured and non-structured activities specific for R4. R5 R5 was admitted on April 19, 2025, with a diagnosis of dementia and resided in the secured dementia care unit. R5's record included an Individualized Activity Plan dated May 15, 2025, which included an	02170		

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02170	Continued From page 26 evaluation of the activity areas required under Minnesota Statute 144G.84. R5's record did not include an individualized activity plan with a daily selection of structured and non-structured activities specific for R5. On July 30, 2025, at 12:50 p.m., CNS-B and LALD-A stated the statutes around individualized activity plans were challenging to interpret. The licensee's Life Enrichment policy revised October 1, 2024, indicated life enrichment systems and programs included getting to know the residents and providing a variety of engaging resident programs. The policy did not address individual activity plans for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Establishment Info

Summerwood of Plymouth
16205 36th Avenue N
Plymouth, MN 55446
Hennepin County
Parcel:

Phone:

License Info

License: HFID 30236

Risk:
License:
Expires on:
CFPM: Anthony Joseph Donato
CFPM #: 25984; Exp: 10/10/2028

Inspection Info

Report Number: F1051251069
Inspection Type: Full - Single
Date: 7/28/2025 Time: 12:01:00 PM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, MICHELLE WINTERS.

DISCUSSED THE FOLLOWING WITH THE CULINARY DIRECTOR, ANTHONY:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE/DISPOSAL

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 F1051251069 from 7/28/2025

Anthony Joseph Donato
Culinary Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Summerwood of Plymouth
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F1051251069
Inspection Type: Full
Date: 7/28/2025
Time: 12:01:00 PM

Food Temperature: Product/Item/Unit: HAM**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: SLICED TOMATOES**; Temperature Process:** Cold-Holding
Location: Prep Rail at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED DELI HAM**; Temperature Process:** Cold-Holding
Location: Prep Rail at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PASTA SALAD**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment: LEFT SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED CHEESE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 39 Degrees F.
Comment: LEFT SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT HONEYDEW**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: DESSERT UPRIGHT COOLER
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN DILL SOUP**; Temperature Process:** Hot-Holding
Location: Warmer at 165 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
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St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Summerwood of Plymouth
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F1051251069
Inspection Type: Full
Date: 7/28/2025
Time: 12:01:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 167 Degrees F.
Comment:
Violation Issued?: No