Electronically Delivered

February 24, 2026

Licensee
Evansville Senior Living
651 State Street Northwest
Evansville, MN 56326

RE: Project Number(s) SL30540016

Dear Licensee:

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

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

STATE CORRECTION ORDERS

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

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30540	A. BUILDING: _____ B. WING _____	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE SENIOR LIVING	651 STATE STREET NW EVANSVILLE, MN 56326

(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: SL30540016-0 On February 9, 2026, through February 11, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 11 residents; eight (8) receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 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	0 470		

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0 470	Continued From page 2 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 16 residents, with a current census of 11 residents. During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Staffing Plan dated August 1, 2023, indicated the previous CNS and LALD for the licensee had developed and implemented the written staffing plan and the Staffing Plan was reviewed on January 17, 2024, August 13, 2024, and January 16, 2025, respectively. The Staffing Plan lacked documentation, which indicated the staffing plan had been reviewed at least twice per year. On February 11, 2026, at 10:51 a.m., LALD-A stated administration and the CNS met often as a group to discuss staffing for the licensee, however, LALD-A stated the last date documented on the staffing plan was January 16, 2025. LALD-A and CNS-F stated the licensee was not aware the staffing plan needed to be reviewed twice per year.	0 470		

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0 470	Continued From page 3 The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the CNS will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The policy did not address how frequently the staffing plan was reviewed. 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 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	0 480		

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0 480	Continued From page 4 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. 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	0 480		

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0 480	Continued From page 5 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 February 9, 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		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 630		

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0 630	Continued From page 6 review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed for one of one unlicensed personnel (ULP)-G, who obtained housing by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 10, 2026, at 7:45 a.m., during observations, licensed practical nurse (LPN)-C stated apartment number 116 did not have any residents residing in the apartment. On February 10, 2026, at 10:23 a.m., assisted living director in residency (ALDIR)-B stated apartment number 116 was occupied by ULP-G who was employed by a temporary agency for the sister skilled nursing facility and ULP-G had stayed at the assisted living for a "few days". ULP-G's employee file lacked evidence an IAPP was developed. On February 11, 2026, at 11:11 a.m., LALD-A stated ULP-G was employed by the licensee's	0 630		

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0 630	Continued From page 7 sister skilled nursing facility and obtained temporary housing by the licensee for four to six weeks. LALD-A further stated the licensee had not developed an IAPP for ULP-G and the licensee was unaware of the requirement. The licensee's 6.05 IAPP policy dated August 1, 2021, indicated the abuse prevention plan for those residents who do not receive any assisted living services may be very limited given the lack of information the facility knows about such "lease-only" individuals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730		

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0 730	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 730		

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0 730	Continued From page 9 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: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Admission/Discharge To/From Report dated August 1, 2025, to February 9, 2026, indicated R1 was discharged on August 3, 2025. R1's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD- difficult breathing), and hypertension (HTN- high blood pressure). R1's Service Plan dated October 1, 2024, indicated R1 received medication administration, housekeeping, and laundry. R1's Progress Notes *NEW* [sic] included the following entry written by licensed practical nurse (LPN)-E: - August 3, 2025: Resident passed away at 03:15 (3:15 a.m.). Hospice and family with resident. Funeral home called and body was taken. Family removed all belongings. Pharmacy aware. R1's record lacked evidence of a discharge summary. On February 11, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-F stated CNS-F was not	0 730		

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0 730	Continued From page 10 aware a discharge summary was required for resident's who were discharged from the assisted living facility. CNS-F further stated when CNS-F began employment CNS-F was told a discharge summary was not required documentation to complete. The licensee's 2.38 Resident Record- Information and Content policy dated August 1, 2021, indicated resident records must include a discharge summary, including service termination notice and related documentation, when applicable. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management	0 900		

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0 900	Continued From page 11 agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written assisted living contract/rental agreement with the required content for one of one unlicensed personnel (ULP)-G, who obtained housing by the licensee. 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	0 900		

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(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
0 900	Continued From page 12 situation has occurred only occasionally). The findings include: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 10, 2026, at 7:45 a.m., during observations, licensed practical nurse (LPN)-C stated apartment number 116 did not have any residents residing in the apartment. On February 10, 2026, at 10:23 a.m., assisted living director in residency (ALDIR)-B stated apartment number 116 was occupied by ULP-G who was employed by a temporary agency for the sister skilled nursing facility and ULP-G had stayed at the assisted living for a "few days". ALDIR-B further stated the licensee had ULP-G sign a contract with the licensee. ULP-G's employee file included a (licensee name) Guest Room Lease Agreement dated January 1, 2026. The agreement indicated the rental term began on January 1, 2026, and ended February 28, 2026. The agreement included the licensee's information, ULP-G's information, and the guest room included shared access to bathroom, kitchen, laundry, living areas, and parking. In addition, the agreement was governed by the laws of the state of MN (Minnesota). ULP-G's employee record lacked evidence the licensee executed a written contract with all required content. On February 11, 2026, at 11:11 a.m., LALD-A	0 900		

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	30540	A. BUILDING: _____ B. WING _____	02/11/2026

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0 900	Continued From page 13 stated ULP-G was employed by the licensee's sister skilled nursing facility and obtained temporary housing by the licensee for four to six weeks. LALD-A further stated the licensee did not execute a written contract with all required content prior to ULP-G moving into the facility, and LALD-A was not aware a full contract was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 14 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	01060		

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01060	Continued From page 15 portion or all of the residents). The findings include: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Admission/Discharge To/From Report dated August 1, 2025, to February 9, 2026, indicated R4 was discharged on February 6, 2026. R4's diagnoses included hypertension (HTN- high blood pressure) and diabetes. R4's Service Plan dated October 1, 2024, indicated R4 received assistance with hearing aids, housekeeping, and laundry. R4's Progress Notes *NEW* [sic] included the following entries: -January 28, 2026: R4 was transported via ambulance to the hospital for further evaluation. -January 31, 2026: R4 is out of facility until further notice. -February 2, 2026: R4 was transferred to another hospital for further evaluation and treatment. Transfer was completed for a higher level of care. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date	01060		

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01060	Continued From page 16 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On February 11, 2026, at 10:53 a.m., LALD-A, clinical nurse supervisor (CNS)-F, and assisted living director in residency (ALDIR)-B stated the licensee was not aware of the emergency relocation requirement and the OOLTC was not notified after R4 did not return to the facility within four days. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, resident's case manager (if applicable), and the OOLTC if the resident does not return to the facility within four days, that contains, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the OOLTC; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 17 -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 review, the licensee failed to ensure the service	01640		

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01640	Continued From page 18 plan was revised to reflect the current services provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included hypertension (HTN- high blood pressure), chronic obstructive pulmonary disease (COPD), acid reflux (heartburn) and congestive heart failure (CHF). On February 10, 2026, at 7:36 a.m., the surveyor observed licensed practical nurse (LPN)-C put on R3's TEDS (compression stockings to promote circulation in the legs). R3 stated staff put on and assist taking off R3's TEDS daily. R3's prescriber orders dated September 19, 2025, included an order to put on R3's TEDS every morning and remove R3's TEDS every night. R3's Individualized Treatment and Therapy Plan V3 [sic] dated November 24, 2025, indicated assistance to put on TEDS on in the morning and	01640		

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01640	Continued From page 19 off at night. R3's Electronic Medication Administration Record (EMAR) dated January 2025, and February 2025, respectively, indicated compression stockings (TEDS) on in the morning and off in the evening shift for edema. R3's Service Plan dated November 5, 2025, indicated unlicensed personnel (ULP) applied TEDS daily, however, R3's service plan lacked removal of R3's TEDS daily. On February 11, 2026, at 9:57 a.m., LPN-C stated evening staff assist R3 to remove TEDS every night. On February 11, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-F stated R3's service plan lacked removal of R3's TEDS and the service plan should have been updated to reflect current services for R3. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated a service plan will include the frequency of each service to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management	01690		

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01690	Continued From page 20 services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy for two of two residents (R2, R5). This practice resulted in a level two violation (a	01690		

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01690	Continued From page 21 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: During the entrance conference on February 9, 2026, at 9:16 a.m., licensed assisted living director (LALD)-A and assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility. On February 10, 2026, at 8:21 a.m., licensed practical nurse (LPN)-C stated the licensee currently did not have any residents receiving narcotic medications. LPN-C opened the locked narcotic box, inside of the locked medication cart, and the following medications were observed: -44 tablets of R2's oxycodone (for pain) 5 milligrams (mg); and -20 tablets of R5's oxycodone (for pain) 5 mg. On February 10, 2026, at 8:58 a.m., ALDIR-B stated clinical nurse supervisor (CNS)-F counted the resident narcotics, along with unlicensed personnel (ULPs) at every shift change. On February 10, 2026, at 9:28 a.m., the surveyor reviewed the above noted medications and the licensee's narcotic log book with LPN-E. LPN-E stated R2's oxycodone was last counted on January 28, 2026, and there was not a narcotic log for R5's oxycodone. LPN-E further stated narcotic medications were supposed to be	01690		

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01690	Continued From page 22 counted at every shift change. R2 and R5's narcotic log records lacked daily counts at shift change per licensee policy. On February 10, 2026, at 1:45 p.m., LPN-C wrote a message in the licensee's online resident medical record system, which indicated the staff are to count narcotics in the bottom drawer when doing shift change and there is a sheet you (ULPs) need to sign after counting. On February 11, 2026, at 11:06 a.m., CNS-F stated when the licensee received narcotics from the pharmacy the staff were responsible to log the narcotics into the narcotic book log. CNS-F further stated the licensee did not complete a daily narcotic count, however, CNS-F counted the narcotics anytime CNS-F set up narcotics into a weekly medication deck (a container used for residents to self-administer medications labeled with the date and time) for residents. The licensee's 7.26 Narcotic Log policy dated August 1, 2021, indicated this is not required, it is a suggested best practice, which included all scheduled II (two) controlled substances will be counted and recorded on the narcotic count sheet and compared with the quantities listed in the Narcotic Log Book [sic]. This will occur at the start of the day shift and during the evening shift. This count will only be recorded in the narcotic count sheet and not on the MAR (medication administration record). In addition, when receiving a new supply of Schedule II (two) [sic] controlled substances, the record on an individual page in the Narcotic Log Book [sic] and count and document the narcotic(s) on the narcotic count sheet [sic].	01690		

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01690	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 9, 2026, at 9:16 a.m., licensed assisted living director (LALD)-A and assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility.	01820		

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01820	Continued From page 24 R3's diagnoses included hypertension (HTN- high blood pressure), chronic obstructive pulmonary disease (COPD), acid reflux (heartburn) and congestive heart failure (CHF). R3's Service Plan dated November 5, 2025, indicated R3's services included medication management (administration) daily. On February 10, 2026, at 7:36 a.m., the surveyor observed licensed practical nurse (LPN)-C administer R3's scheduled morning medication. R3's Electronic Medication Administration Record (EMAR) dated January 2025, and February 2025, respectively, indicated R3 was administered omeprazole (for acid reflux) 20 milligrams (mg) daily unsupervised self-administration. R3's prescriber orders dated February 28, 2025, included an order for omeprazole one time daily on an empty stomach. No food for 30 minutes. Can drink Water. Patient (resident) would like to have in his room to be able to take right away after waking. R3's record lacked a prescriber order to include the omeprazole dosage to be taken. On February 11, 2026, at 11:37 a.m., clinical nurse supervisor (CNS)-F stated R3's omeprazole order did not indicate what dosage to administer to R3. CNS-F further stated all prescriber orders needed to include the medication dosage amount for any medication a resident was taking. The licensee's 7.20 Medication and Treatment Orders policy dated August 1, 2021, indicated an	01820		

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01820	Continued From page 25 order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of two residents (R3) who received medication management services. 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:	01830		

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(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
01830	Continued From page 26 During the entrance conference on February 9, 2026, at 9:16 a.m., licensed assisted living director (LALD)-A and assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility. R3 was admitted to the licensee on January 10, 2024. R3's diagnoses included hypertension (HTN- high blood pressure), chronic obstructive pulmonary disease (COPD), acid reflux (heartburn) and congestive heart failure (CHF). R3's Service Plan dated November 5, 2025, indicated R3's services included medication management (administration) daily. R3's Electronic Medication Administration Record (EMAR) dated February 2026, indicated the following medications were scheduled and administered: -amlodipine (antihypertensive) 5 milligrams (mg) daily -cetirizine HCL (for allergies) 10 mg daily -Doxazosin Mesylate (for benign prostatic hyperplasia) 4 mg daily -fish oil (for heart health) 1200 mg daily -Glucosamine-Chondroitin-MSM (for arthritis) 2 tablets daily -hydrochlorothiazide (antihypertensive) 25 mg daily -omeprazole (antacid) 20 mg daily self-administration -Pramipexole Dihydrochloride (for restless legs syndrome) 0.125 mg daily -PreserVision AREDS 2 (for macular degeneration) 1 capsule daily -vitamin B-12 (supplement) 1000 micrograms	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30540	A. BUILDING: _____ B. WING _____	02/11/2026

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01830	Continued From page 27 (mcg) daily -gabapentin (for neuropathy) 100 mg three times per day On February 10, 2026, at 7:36 a.m., the surveyor observed licensed practical nurse (LPN)-C administer R3's scheduled morning medication. R3's prescriber orders dated February 28, 2025, and August 25, 2025, respectively, included orders for omeprazole (lacked dosage) and gabapentin. R3's prescriber orders dated June 21, 2024, included orders for amlodipine, calcium carbonate, cetirizine HCL, Doxazosin Mesylate, fish oil, Glucosamine-Chondroitin-MSM, hydrochlorothiazide, Pramipexole Dihydrochloride, PreserVision AREDS2, and vitamin B-12. R3's record lacked annual (every 12 months) prescriber orders for all medications except omeprazole and gabapentin. On February 11, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-F stated R3's record lacked annual orders for the above noted medications. CNS-F further stated the licensee had not obtained annual prescriber orders and only added new prescriber orders to resident's medical records. The licensee's 7.18 Medication and Treatment Orders- Renewal policy dated August 1, 2021, indicated medication orders will be sent to the resident's authorized prescriber for signatures at least every 12 months. No further information was provided.	01830		

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	30540	A. BUILDING: _____ B. WING _____	02/11/2026

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01830	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to specify, in writing, specific instructions for one of one resident (R3) receiving treatment management services. 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	01950		

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01950	Continued From page 29 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 February 9, 2026, at 9:22 a.m., licensed assisted living director (LALD)-A and assisted living director in residency (ALDIR)-B stated the licensee provided treatment and therapy services to residents. R3's diagnoses included hypertension (HTN- high blood pressure), chronic obstructive pulmonary disease (COPD), acid reflux (heartburn) and congestive heart failure (CHF). R3's Service Plan dated November 5, 2025, indicated unlicensed personnel (ULP) applied TEDS daily. R3's Individualized Treatment and Therapy Plan V3 [sic] dated November 24, 2025, indicated assistance to put on TEDS on in the morning and off at night. R3's Electronic Medication Administration Record (EMAR) dated January 2025, and February 2025, respectively, indicated compression stockings (TEDS) on in the morning and off in the evening shift for edema. On February 10, 2026, at 7:36 a.m., the surveyor observed licensed practical nurse (LPN)-C put on R3's TEDS (compression stockings to promote circulation in the legs). R3 stated staff put on and assist taking off R3's TEDS daily.	01950		

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01950	Continued From page 30 R3's record lacked specific written instructions for ULPs to notify the RN when a problem arises regarding TEDS. On February 11, 2026, at 11:32 a.m., clinical nurse supervisor (CNS)-F stated R3's treatment plan lacked written instructions of when to notify the RN if problems arose with R3's TEDS. CNS-F further stated resident treatments were supposed to include written instructions of when to notify the RN when problems arose. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 1, 2021, indicated (licensee name) will develop and maintain a current individualized treatment and therapy management record for each resident, which included procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02310		

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02310	Continued From page 31 review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R2) who utilized bedrails. 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: During the entrance conference on February 9, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included diabetes, major depressive disorder, and chronic heart failure (CHF). R2's Service Plan dated February 6, 2025, indicated R2's services included medication administration, assistance with bathing and dressing, and housekeeping. On February 10, 2026, at 11:19 a.m., the surveyor observed licensed practical nurse (LPN)-C administer R2's scheduled insulin. During the observation, the surveyor observed a consumer bed rail on R2's left side of R2's bed. The consumer bedrail was an upside down U-shaped white bed rail with three horizontal bars across. The top of the consumer bedrail had a	02310		

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02310	Continued From page 32 black padding attached. R2 and LPN-C stated R2 did not sleep in R2's bed and R2 did not use the consumer bedrail. R2's Side Rail Use Assessment Form- V 3 [sic] dated October 29, 2025, indicated R2 had a side rail used to get out of bed. R2 was not currently using the side rail for positioning or support. R2 was cognitive, expressed desire to have the side rails installed, and the side rail was not being used as a restraint. The positive and negative aspects of the side rails have been discussed, a bed rail brochure was given to R2 and R2's daughter, and the side rail was used to assist with getting out of bed. R2's Uniform Assessment Tool (MN) (Minnesota)- V 2 [sic] dated January 20, 2026, indicated R2 had a grab bar (bedrail) on the left side of R2's bed. R2 used the bedrail to aid in adjusting and getting out of bed. The grab bar is secured to the bed and sturdy. The grab bar has only one zone/open area approximately 4 inches by 16 inches. R2 was independent with bed mobility. R2's record lacked documentation the licensee reviewed the Consumer Product Safety Commission (CPSC) website to ensure R2's bedrail was not recalled. On February 11, 2026, at 11:21 a.m., clinical nurse supervisor (CNS)-F stated bedrail assessments were completed every 90 days with the comprehensive assessment for each resident, however, the bedrail assessments did not include verification the CPSC website was checked for bedrail recalls. LALD-A further stated the licensee received weekly reports on bedrail recalls from the assisted living provider association of which the licensee was a member.	02310		

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02310	Continued From page 33 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 13, 2025 indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's bedrails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for consumer bedrails the CSPC website needed to be checked for consumer bedrails at least every 90 days. The licensee's 6.25 Side Rails (bedrails) policy	02310		

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02310	Continued From page 34 dated August 1, 2021, indicated if (licensee name) is aware a home care resident is utilizing side rails (a medical device) on a bed, (licensee name) will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with manufacturer's directions [sic]. In addition, a registered nurse (RN) must conduct an assessment to identify the intended purpose of the side rail and the risk regarding the use of the side rail. Assessments and education procedures must still be followed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Evansville Senior Living
651 State Street NW
Evansville, MN 56326
Douglas County
Parcel:

Phone:

License Info

License: HFID 30540

Risk:
License:
Expires on:
CFPM: Sherri Enderson
CFPM #: 63040; Exp: 10/29/2028

Inspection Info

Report Number: F7935261019
Inspection Type: Full - Single
Date: 2/9/2026 Time: 11:09:47 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: Need a Max/Min thermometer to check final rinse temperature in dish machine.

Comply By: 2/28/2026 Originally Issued On: 2/9/2026

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 Fergus Falls District Office inspection report number F7935261019 from 2/9/2026

Establishment Representative

Rebecca Tonneson

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Evansville Senior Living
Evansville
County/Group: Douglas County

Inspection Info

Report Number: F7935261019
Inspection Type: Full
Date: 2/9/2026
Time: 11:09:47 AM

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 33 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Evansville Senior Living
Evansville
County/Group: Douglas County

Inspection Info

Report Number: F7935261019
Inspection Type: Full
Date: 2/9/2026
Time: 11:09:47 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No