Electronically Delivered

July 13, 2026

Licensee
Traditions of Preston
515 Washington Street Northwest
Preston, MN 55965

RE: Project Number(s) SL26354016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Traditions of Preston. Please contact Jodi Johnson at 507-344-2730 **on or before Thursday July 16, 2026,** to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26354	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF PRESTON	515 WASHINGTON STREET NW PRESTON, MN 55965

(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: SL23654016-0 On June 1, 2026, through June 4, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider and the following correction orders are issued. At the time of the survey, there were 25 residents; 22 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.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100		

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0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100		

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0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants operate on the lower level of the building, and the licensee does not have access to all areas of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Upon arrival at the facility on June 1, 2026, at 11:00 a.m., the surveyor observed the assisted living with dementia care facility was located in a building sharing the same roof with a community	0 100		

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0 100	Continued From page 3 food bank and had separate entrances. On June 1, 2026, at 12:24 p.m., the surveyor and resident care coordinator (RCC-C) toured the licensee's building. She stated the licensee only used the first floor of the facility and shared part of the building (same roof with a separate entrance) with a community food shelf. The community food shelf was operating in the basement of the assisted living building, directly below the dementia care unit. There was a one hour labeled fire door between the assisted living stairwell and the food shelf. There was not a vertical two-hour fire barrier between the licensed assisted living facility and the food shelf. The community food shelf was not properly separated from the licensed assisted living facility. 144G.08 DEFINITIONS Subd. 7. Assisted living facility. Assisted living facility means a facility that provides sleeping accommodation and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include: (1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361; (2) a nursing home licensed under chapter 144A; (3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56; (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D, 245G, or 245I;	0 100		

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0 100	Continued From page 4 (5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D; (6) a private home in which the residents are related by kinship, law, or affinity with the provider of services; (7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593; (9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing; (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services; (11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q; (12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under	0 100		

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0 100	Continued From page 5 Code of Federal Regulations, title 24, section 983.56; (13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or (15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence. Minnesota Statutes 144G.08 Definitions. Subdivision 59. "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 59. Resident. Resident means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 5. Assisted living contract. Assisted living contract means the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		
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.	0 480		

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0 480	Continued From page 6 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480		

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0 480	Continued From page 7 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 1, 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		

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0 570	Continued From page 8	0 570		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 1, 2026, at 12:24 p.m., the surveyor observed the facility entrance area for the required postings and did not observe the facility's license. On June 1, 2026, at 12:45 p.m., resident care coordinator (RCC)-C stated she did not know the license was not posted. Furthermore, licensed assisted living director (LALD)-A stated the license should be posted and would look into it's location. The licensee's Assisted Living License and	0 570		

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0 570	Continued From page 9 Posting policy dated August 2024, indicated [licensee name] will maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license will be posted at the main assisted living entrance and the memory care entrance (if applicable) of the community. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 10 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the Emergency Preparedness (EP) plan prominently. In addition, the licensee failed to post clearly written emergency exit diagrams in general publicly used hallways of the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on June 1, 2026, at 12:45 p.m. with resident care coordinator (RCC)-C, the surveyor observed postings on the walls and wing/memory care unit. The EP plan was not prominently displayed for residents or visitors. Additionally, RCC-C stated emergency exit diagrams were posted on the inside of each resident apartment door; however, no emergency exit diagrams were noted in the general hallways or within the memory care unit. On June 1, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee's EP plan was housed in several areas and there had been signage in the entryway of the facility	0 680		

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0 680	Continued From page 11 indicating where the EP manual could be found; however, there was no signage. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota	0 775		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF PRESTON	515 WASHINGTON STREET NW PRESTON, MN 55965

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0 775	Continued From page 12 Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 13 Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	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	0 810		

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0 810	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 16 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of 25 employees (unlicensed personnel (ULP-D, ULP-I) were affiliated with the assisted living license as required. This had the potential to affect all residents. 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: ULP-D ULP-D was hired on July 12, 2022, to provide direct care services independently to the licensee's residents. On June 1, 2026, at 2:20 p.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record contained a background study dated October 24, 2025, for a separate location (the licensee's other assisted living facility). ULP-C's record lacked evidence that the licensee affiliated a background study for this assisted living with dementia care facility. ULP-I ULP-C was hired on November 10, 2025, to provide direct care services independently to the	01290		

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01290	Continued From page 18 licensee's residents. ULP-I's employee record contained a background study dated November 4, 2025, for a separate location (the licensee's other assisted living facility). ULP-I's record lacked evidence that the licensee affiliated a background study for their assisted living with dementia care facility. On June 2, 2026, at 10:55 a.m., licensed assisted director (LALD)-A stated both ULP-D and ULP-I background studies were associated with a "sister" facility and the sensitive information person (SIP) was the same person and received background study clearance information for both facilities. The licensee's Background Studies policy dated August 2024, indicated the licensee would conduct a background study on all employees and volunteers and contractors. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the	01320		

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01320	Continued From page 19 topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training was completed for one of two unlicensed personnel (ULP-I) to include all required content. 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: ULP-I was hired on November 10, 2025, and provided direct care services to the facility's residents. ULP-I's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and	01320		

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01320	Continued From page 20 -understanding appropriate boundaries between staff and residents and the residents' family On June 4, 2026, at 12:05 p.m., licensed assisted living director (LALD)-A stated ULP-I either did not complete all her assigned training or failed the training topic; therefore, it was not listed on her training transcript, and was not considered as completed. The licensee's Competency Training Evaluations policy dated August 2024, included: 5. Training and competency evaluations for all ULPs will include: - Documentation requirements for all services provided; - Training on the prevention of falls; and - Understanding appropriate boundaries between staff and residents and the residents' family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare	01330		

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01330	Continued From page 21 for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of four unlicensed personnel (ULP-F , ULP-I) to include all required content. 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: ULP-F ULP-F was hired on July 25, 2024, and provided direct care services to the residents residing within the assisted living with dementia care facility. On June 2, 2026, at 7:10 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee record lacked evidence of competency testing for the following topics:	01330		

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01330	Continued From page 22 - compression stockings; - ace wraps (compression wraps); and - continuous positive airway pressure (CPAP) (a machine worn at bedtime to assist with sleep apnea) ULP-I ULP-I was hired on November 10, 2025, and provided direct care services to the residents residing within the assisted living with dementia care facility. ULP-I's employee record lacked evidence of competencies for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; - stand by assistance techniques and how to perform them; - safe transfer techniques and ambulation; and - range of motioning and positioning Additionally, UP-I's employee record lacked evidence of competency testing for: - compression stockings; - ace wraps (compression wraps); and - CPAP On June 4, 2026, at 12:10 p.m., licensed assisted living director (LALD)-A stated the previous registered nurse (RN) used a different set of training documents and the above listed competencies were missing in ULP-F and ULP-I's training packets, and were not signed off by the registered nurse. The licensee's Competency Training Evaluations policy dated August 2024, indicated training and	01330		

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01330	Continued From page 23 competency evaluation for unlicensed personnel providing assisted living services must include: e. Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing; ii. care of teeth, gums, and oral prosthetic devices; iii. care and use of hearing aids; iv. dressing and assisting with toileting; g. Standby assistance techniques and how to perform them; e. Safe transfer techniques and ambulation; and f. Range of motioning and positioning Additional nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by a RN include: - thromboembolism deterrent (TED) stockings; - C-PAP machines No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 24 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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01470	Continued From page 25 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-I) received orientation to assisted living facility licensing requirements and regulations before providing 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: ULP-I had a hire date of November 10, 2025, to provide personal care to the licensee's residents. ULP-I's record lacked evidence she received orientation to assisted living facility to include the following required content: - an overview of Assisted Living Statutes On June 4, 2026, at 12:05 p.m., licensed assisted living director (LALD)-A stated the above training had been assigned; however, ULP-I did not complete it.	01470		

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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
01470	Continued From page 26 The licensee's Orientation of Staff and Supervisors and Content policy dated August 2024, indicated all staff of [management name] providing and supervising direct services must complete an orientation to assisted living community licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: - An overview of the appropriate assisted living statutes and rules No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 27 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01500		

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01500	Continued From page 28 licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F). 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: ULP-F began providing direct care services on July 25, 2024, under the licensee's assisted living with dementia care license. ULP-F's employee record lacked evidence that the employee had successfully completed annual training to include the following required topics: -reporting maltreatment of vulnerable adults or minors; -effective approaches to use to problem solve when working with a resident's challenging behaviors, how to communicate with residents who have dementia, Alzheimer's disease or related disorders; and -principles of person-centered planning/service delivery On June 4, 2026, at 12:10 p.m., licensed assisted living director (LALD)-A stated ULP-F was assigned the above listed annual training topics; however, she had not yet completed them. The licensee's Annual Required Staff Training	01500		

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01500	Continued From page 29 policy dated August 2024, indicated the following training elements MUST be included every 12 months for all staff who performs direct care services: - Training on reporting of maltreatment of vulnerable adults under the appropriate state guidelines; - Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new	01540		

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01540	Continued From page 30 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one employee (ULP)-I) received the required amount of dementia training in the required time frame. 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. ULP-I had a hire date of November 10, 2025, to provide direct care services to the licensee's residents. ULP-I's employee record contained evidence of completing 6.5 hours of dementia training; however, she lacked an additional 1.5 hours to meet the required eight hours of training within 80 hours of employment.	01540		

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01540	Continued From page 31 On June 4, 2026, at 12:15 p.m., licensed assisted living director (LALD)-A stated she assigned all new employee onboarding training courses including dementia training. She stated the licensee used an online training system that had training packages including dementia training modules that were auto assigned. LALD-A stated she had never determined the total number of hours the "package" for dementia modules included. After further review of other employee training transcripts, LALD-A stated she did not realize she was only assigning between 6.5 and seven hours of dementia related training for new employees and would need to pick another couple of topics to meet the minimum requirement of eight hours of dementia related training. LALD-A stated ULP-I had worked greater than 80 hours since her start of employment. The licensee's Dementia Training policy dated August 2024, indicated direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=E	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	01620		

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01620	Continued From page 32 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an 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	01620		

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01620	Continued From page 33 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 observation, interview, and record review, the licensee failed to conduct a 14-day assessment following admission and failed to conduct a comprehensive reassessment with a change of condition for one of two residents (R5) and lacked accurate and ongoing wound assessment information (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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: 14 DAY ASSESSMENT R5 began receiving services on July 14, 2025, with diagnoses including type 2 diabetes with insulin dependence, diabetic related kidney disease, and neuropathy (nerve pain), and congestive heart failure on blood thinners. R5's Service Plan dated April 23, 2026, indicated he received services including blood sugar checks, assistance with bathing, medication administration/management, wound cleansing, daily weights, and behavior management. On June 2, 2026, at 9:00 a.m. the surveyor	01620		

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01620	Continued From page 34 observed unlicensed personnel (ULP)-H administer five oral medications and two injections to R5. ULP-H stated R5's "toe care" had already been completed earlier in the morning. R5's record included comprehensive assessments dated: -July 9, 2025, as an admission assessment -October 7, 2025, 90-day assessment -December 15, 2025, 90-day assessment -January 6, 2026, labeled as a change in condition assessment -April 6, 2026, 90-day assessment R5's record lacked comprehensive reassessment completed 14 days following his admission date. On June 4, 2026, at 11:05 am., clinical nurse supervisor (CNS)-B stated the nurse previous to her completed R5's comprehensive assessments at the time of his admission in July 2025, through January 2026, and appeared to have assigned the next comprehensive assessment following admission as a 90 day assessment in error; therefore, did not have the reminder to complete a 14 day assessment following R5's admission. CHANGE IN CONDITION R5's progress note dated January 6, 2026, indicated R5 was transported to [hospital name] and admitted. R5's progress note dated January 9, 2026, indicated R5 returned to the facility following a hospitalization for Influenza A and included various medication changes. R5's after visit summary (AVS) dated January 9,	01620		

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01620	Continued From page 35 2026, indicated R5 was hospitalized from January 6, 2026, through January 9, 2026, for altered mental status, fever, hypoxia (low blood oxygen levels) and Influenza A. R5's record included comprehensive assessment dated January 6, 2026, and was labeled as an assessment for a change in condition. This assessment was completed prior to R5's hospitalization that same day. R5's record lacked a comprehensive assessment for a change in condition following his hospitalization on January 9, 2026. On June 4, 2026, at 11:10 a.m., CNS-B stated she was not the licensee's nurse at that time and could not find any assessment following that hospitalization outside the assessment she completed in April 2026. WOUND ASSESSMENT R5's AVS (After Visit Summary) dated January 15, 2026, indicated a diagnosis of diabetic ulcer of toe of right foot associated with type 2 diabetes mellitus, limited to breakdown of skin and indicated right toe wound-the wound does not appear infected, but the foot is notably cold, suggesting possible compromised blood flow. A referral to a vascular specialist will be made for further evaluation. A nurse will be assigned to daily wound care and INR (international normalized ratio- measures the time taken for blood to clot) monitoring to prevent infection. R5's progress notes from December 8, 2025, through June 1, 2026, included the following entries regarding his right great toe: - January 14, 2026 - Cut on right great toe. Staff	01620		

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01620	Continued From page 36 reported that last evening blood was noted on the floor of resident's room, and he informed staff that he "cut it himself to relieve pressure on his foot." Staff provided first aid and applied simple dressing to toe. Photo was sent of injury by staff to the nurse phone, and there is a small cut on tip of the right great toe, bleeding appears to have stopped. - January 15, 2026 - Provider examined right great toe and recommended home health care for R great toe wound - January 16, 2026 - Home Health will be out "in the next 2 days" to admit resident to home health for right toe wound care and International Normalized Ratio [INR] management [a blood test to measure blood clotting time when on blood thinners]. right great toe wound. Writer received call from RN at [clinic name] indicating [staff] called clinic stating "[R5's] band aid fell off his toe". Resident was seen by primary care provider [PCP] on Thursday [January 15, 2026] and orders were sent to [home health agency name] for INR and right [R] great toe wound management. Writer notified assisted living resident assistant [RA] to apply band aid to R great toe and notify RN if bleeding, redness, swelling, or pain. [Home health agency name] will admit resident on Tuesday 1/20/26. Instructions per clinic RN to keep clean, dry, and covered with band aid. RA task added for daily monitoring of R great toe. -January 20, 2026 - Resident admitted to [home health agency name] for wound care and INR management. -March 24, 2026 - [home health agency name] suggested resident goes Urgent care today as his right great toe looks infected. -April 7, 2026 - Regarding his right great toe wound RN had asked if RN could get an order for Betadine. RN was informed that [provider name] would like it washed with soap and water twice	01620		

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01620	Continued From page 37 and day and covered with a band-aid. R5's Task Administration Record dated June 2026, indicated "staff to cleanse right great toe at nail bed with soap and water twice daily, dry thoroughly and place a band aid." R5's comprehensive assessments dated April 6, 2026, read "no" to the questions: "Does the resident have any skin conditions? Does the resident require monitoring or assistance with skin care?" The licensee failed to accurately depict R5's right great toe concern with comprehensive assessments and failed to document or regularly assess the condition of R5's right great toe. On June 4, 2026, at 11:15 a.m., CNS-B stated the ULP were washing R5's right great toe with soap and water twice daily and the homecare agency nurse that came to check R5's INR was following the condition of his toe. CNS-B stated the home care nurse did not provide reports or documentation regarding R5's toe. CNS-B stated since the home health agency was following the condition of the toe, she didn't know she still needed to assess it herself. CNS-B further stated she didn't realize she missed the skin concern with R5's toe with the most recent comprehensive assessment she completed in April 2026. The licensee's Assessments, Reviews, and monitoring policy dated August 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 38 from the last date of the assessment. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow delegated procedures for medication administration for one of seven residents (R9). 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).	01750		

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01750	Continued From page 39 The findings include: R9 began receiving services under the licensee's Assisted Living with Dementia Care license on March 13, 2026, with diagnoses including Alzheimer's disease and hypertension. R9's Service Agreement dated April 23, 2026, included the service of medication management/administration. R9's medication administration record (MAR) dated June 2026, indicated R9 received two medications for dementia, one for depression, one for sleep/agitation, two for hypertension, two for constipation, one for nerve pain, two for general pain, and one topical pain medication. R9's signed prescriber's orders dated May 30, 2026, included diclofenac 1% gel, apply 2 grams (gm) to lower back and both knees three times daily for pain. On June 2, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-F don gloves, squirt an undetermined amount of diclofenac 1% gel to her gloved index finger and apply it to R9's lower back and both of R9's knees. When asked about the proper dose of diclofenac gel, ULP-F stated she just squirts a small amount on her finger and rubs into the skin of each of R9's knees and further stated she did not know how much it was. ULP-F stated she was not aware of the measuring strip included with each tube of diclofenac gel. The licensee failed to use the appropriate measuring tool to administer the correct dosage of diclofenac gel.	01750		

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01750	Continued From page 40 On June 2, 2026, at 10:52 a.m. clinical nurse supervisor (CNS)-B stated the ULP have been trained to use the measuring tool; however, she would work to retrain all staff who pass medications. The licensee's Medication Administration policy dated August 2024 indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 facility failed to renew prescriptions at least every 12 months for one of six residents	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26354	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF PRESTON	515 WASHINGTON STREET NW PRESTON, MN 55965

(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 41 (R13). 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: R13 began receiving services on September 1, 2021, with diagnoses including history of stroke and hypertension. R13's Service Plan dated May 21, 2026, indicated she received services including medication management/administration. On June 2, 2026, at 8:15 a.m., the surveyor observed ULP-G assist R13 with a whirlpool bath and don compression stockings. ULP-G stated R13 had received her medications earlier in the morning. R13's medication administration record (MAR) dated June 2026, indicated the following medications: - amlodipine 10 milligrams (mg), give one tablet by mouth daily for hypertension; - atorvastatin 40 mg, give one tablet by mouth daily at bedtime for cholesterol; - furosemide 20 mg, give one tablet by mouth every morning for water retention; - lisinopril 40 mg, give one tablet by mouth every morning for hypertension; - metoprolol 100 mg, extended relief (ER) give	01830		

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01830	Continued From page 42 one tablet daily for heart rate management; - pantoprazole 40 mg, give one tablet by mouth twice daily before morning and evening meals for gastric reflux; - vitamin D3 25 micrograms (mcg), give one tablet daily as a supplement; - acetaminophen 500 mg, give two capsules by mouth three times daily for mild pain; - polyethylene glycol, mix 17 grams (gm) in liquid and take by mouth once daily as needed for constipation; - senna-time 8.6 mg, take one tablet by mouth once daily as needed for constipation; - acetaminophen 500 mg, give two tablets by mouth daily as needed in addition to scheduled for mild pain; - diclofenac gel 1%, give 2 gm to left knee four times daily as needed for pain The licensee provided a medication list which included the above listed medications signed by R13's provider dated October 30, 2024. The licensee failed to ensure prescriptions were renewed at least every 12 months as required. On June 3, 2026, at 4:00 p.m., clinical nurse supervisor (CNS)-B stated she was unable to find an updated prescriber's order for R13's medications. The licensee's Medication and Treatment Orders-Renewal policy dated August 2024, indicated residents who receive medication management services by [licensee name] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required.	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRADITIONS OF PRESTON	515 WASHINGTON STREET NW PRESTON, MN 55965

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01830	Continued From page 43 No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date for two of three residents (R3, R5) with insulin administration, include a proper label for three of ten residents (R2, R4, R5) with medication administration, and failed to ensure medications included an expiration date for one of ten (R4) residents with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings included:	01890		

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01890	Continued From page 44 OPEN DATE On June 1, 2026, at 2:30 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the contents of the assisted living medication cart. ULP-D confirmed the following: - R3 Wixela inhaler one dose used, no open date. Inhaler package included instructions indicating discard one month after opening foil. - R5 Lantus 100 u/ml lacked an open date PROPER LABEL On June 1, 2026, at 2:30 p.m., the surveyor and ULP-D reviewed the contents of the assisted living medication cart. ULP-D confirmed the following: - R2 diclofenac 1% gel lacked a proper label (included only handwritten initials) - R4 Lantus 100 units/milliliter (u/ml) autoinjector included a handwritten open date on the insulin pen; however, it lacked a proper label - R5 Ozempic auto injector included a handwritten open date; however, lacked a proper label EXPIRATION DATE On June 1, 2026, at 2:30 p.m., the surveyor and ULP-D reviewed the contents of the assisted living medication cart. ULP-D confirmed the following: -R4 acetaminophen 500 mg bubble pack as set up by the licensee's nurse. 23 tablets remain in bubble pack. The bubble pack lacked an expiration date to indicate when the acetaminophen was no longer safe to administer. On June 2, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of missing labels, lack of open dates, and lack of an expiration date and would review the medication	01890		

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01890	Continued From page 45 cart and re-educate the ULP who passed medications. Lantus insulin manufacturer's instructions dated 2022, indicated do not refrigerate after opening, and discard after 28 days once opened/used even if insulin is still present in the pen. The licensee's Medication Prescription Drugs and Prohibition policy dated August 2024, indicated when [licensee name] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 46 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of three residents (R5, R13) with treatments/delegated tasks. 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:	01940		

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01940	Continued From page 47 During the entrance conference on June 1, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents as prescribed. R5 R5 began receiving services on July 14, 2025, with diagnoses including type 2 diabetes with insulin dependence, diabetic related kidney disease, and neuropathy (nerve pain), and congestive heart failure on blood thinners. R5's Service Plan dated April 23, 2026, indicated R5 received services including blood sugar checks, wound cleansing, and daily weights. On June 2, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-H administer five oral medications and two injections to R5. ULP-H stated R5's "toe care" had already been completed earlier in the morning. WOUND CARE R5's After Visit Summary (AVS) dated January 15, 2026, indicated a diagnosis of diabetic ulcer of toe of right foot associated with type 2 diabetes mellitus, limited to breakdown of skin and indicated right toe wound-the wound does not appear infected, but the foot is notably cold, suggesting possible compromised blood flow. A referral to a vascular specialist will be made for further evaluation. A nurse will be assigned to daily wound care and INR monitoring to prevent infection. R5's progress note dated April 7, 2026, read "regarding his right great toe wound RN had	01940		

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01940	Continued From page 48 asked if RN could get an order for Betadine. RN was informed that [provider name] would like it washed with soap and water twice and day and covered with a band-aid. R5's Task Administration Record dated June 2026, indicated: -wound care-staff to cleanse right great toe at nailbed with soap and water twice daily and dry thoroughly and place band aid The licensee failed to provide written instructions regarding what the ULP should monitor for and report to nursing regarding changes in R5's right great toe care . DAILY WEIGHTS R5's prescriber's order dated March 27, 2026, indicated "ok to do daily weights." R5's AVS (After Visit Summary) dated April 26, 2026, included a new order for furosemide (a medication used for fluid retention sometimes related to heart failure) 20 milligrams (mg), give two tablets daily. R5's Task Administration Record dated June 2026, indicated: -daily weight-staff to take resident weight first thing in the morning and chart The licensee failed to provide written instruction regarding management of R5's daily weights regarding weight parameters which needed to be reported to nursing. R13 R13 began receiving services on September 1, 2021, with diagnoses including history of stroke and hypertension.	01940		

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01940	Continued From page 49 R13's Service Plan dated May 21, 2026, indicated she received services including assistance with compression stockings. On June 2, 2026, at 8:15 a.m., the surveyor observed ULP-G assist R13 with a whirlpool bath and don compression stockings. R13's Task Administration Record dated June 2026, indicated staff to provide assistance with applying compression stockings, assuring they are wrinkle free in the morning and taking off at night. R13's signed prescriber's order dated October 30, 2024, indicated compression stockings (knee high) and included measurements for the stockings. (The order was not renewed annually). The licensee failed to provide written instruction regarding management of R13's compression stockings, in what the ULP should monitor for and report to nursing. On June 4, 2026, at 12:05 p.m. CNS-B stated she was not aware she needed to include written instructions with treatments or delegated tasks for the ULP. The licensee's Treatment and Therapy Management Plan policy dated August 2024, indicated [licensee name]will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: b. Documentation of specific resident instructions relating to the treatments or therapy administration	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R13) receiving treatments. 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: R13 began receiving services on September 1, 2021, with diagnoses including history of stroke	01970		

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01970	Continued From page 51 and hypertension. R13's Service Plan dated May 21, 2026, indicated she received services including assistance with compression stockings. On June 2, 2026, at 8:15 a.m., the surveyor observed ULP-G assist R13 with a whirlpool bath and don compression stockings. R13's Task Administration Record dated June 2026, indicated staff to provide assistance with applying compression stockings, assuring they are wrinkle free in the morning and taking off at night. R13's signed prescriber's order dated October 30, 2024, indicated compression stockings (knee high) and included measurements for the stockings. The licensee failed to ensure R13's prescriber's order for compression stockings was up to date and maintained on an annual basis as required. On June 3, 2026, at 12:25 p.m. clinical nurse supervisor (CNS)-B stated she could not find any orders for R13's compression stockings since October 2024. The licensee's Medication and Treatment Orders-Renewal policy dated August 2024, indicated residents who receive medication management services by [licensee name] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 52 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Food & Beverage Inspection Report

Establishment Info

TRADITIONS HOLDINGS LLC
515 WISHINGTON STREET NW
PRESTON, MN 55965
Fillmore County
Parcel:

Phone:
tschaber@cornerstonemgmt.com

License Info

License: HFID 26354
Tracie Schaber
Risk:
License:
Expires on:
CFPM: Tracie Schaber
CFPM #: FM3153; Exp: 12/14/2027

Inspection Info

Report Number: F1045261082
Inspection Type: Full - Single
Date: 6/1/2026 Time: 1:12:18 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT:
Deli sliced ham and turkey observed open and lacking any date mark. Supervisor discarded product during inspection
Comply By: Complied On Site Originally Issued On: 6/1/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
Firm uses a quaternary RTU solution for cleaning equipment, table tops etc... Obtain test strips to ensure safe levels of sanitizer.

Strips ordered during inspection
Comply By: Complied On Site Originally Issued On: 6/1/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT:
Old product residue observed on the blade of the large can opener.
Comply By: 6/1/2026 Originally Issued On: 6/1/2026

Food & Beverage General Comment

Food safety inspection of the food preparation, storage and service areas for the assisted living and memory care locations.

Items reviewed: Ill employee policy, handwashing practices and glove usage, thermometer calibration, hot and cold holding, warewashing, date marking

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans

and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F1045261082 from 6/1/2026

Melissa Vick Wruck
Culinary Supervisor

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL26354016-0	**Date:** June 3, 2026
Facility Name: Traditions Holdings LLC	
Facility Address: 515 Washington Street NW, Preston, MN 55965	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments:
   - A fire door was missing from one of the labeled fire door frames for the basement mechanical room.
   - A basement mechanical room labeled fire door was propped open with a wedge.
   - The labeled fire door for the food shelf storage room was held open with a kick down doorstop.
   Fire doors shall be maintained to prevent the spread of smoke and fire in the event of an emergency.

3. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit.

   Comments: There were two doors with controlled egress locks in sequence that would require the building occupants to pass through two locked doors to exit the dementia care unit from the spa.

4. The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   Comments: In the dementia care unit, emergency lights labeled four and seven, did not work when tested by regional maintenance manager (RMM)-J. The surveyor requested emergency light testing records from the licensee, and these requested records were not available.

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

   Comments: The annual inspection tag attached to the fire sprinkler system was dated June 2024. Regional maintenance manager (RMM)-J stated they were aware this inspection was past due and had already scheduled this inspection.

6. Extension cords and flexible cords shall not be a substitute for permanent wiring.

   Comments: Extension cords were used to supply power to personal electronics in resident room five and in the spa room.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: In occupied resident apartment three, when regional maintenance manager (RMM)-J tested the bedroom smoke alarm, the smoke alarm outside the bedroom was not actuated. The smoke alarms in this dwelling unit were not interconnected.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:
   - One handrail for the main entrance exterior stairs was loose.
   - There were water stained ceiling tiles in occupied resident rooms two and five. Regional maintenance manager (RMM)-J stated new tiles were already on order as they were aware these tiles required replacement.
   - There were several water stained and sagging ceiling tiles in the basement stairwell.
   - The light bulb was burnt out in the bathroom light fixture on the ceiling in resident room 14.

- There was a hole at the bottom of the bedroom door in resident room 16.
- There were holes in the wall in the furnace/water heater closet on the main floor. Regional maintenance manager (RMM)-J stated these holes were created when recent HVAC work was completed.
- There were several small holes in the spa room door near the door closer on the dementia care side.
- The surveyor requested inspection and load test reports for the emergency power generator from the licensee. The licensee responded that these requested reports were not available. The licensee failed to meet the minimum inspection and testing frequency requirements for the emergency power generator to ensure proper performance.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The provided fire safety and evacuation plan (FSEP) binders included a fire evacuation resident roster but failed to include individualized evacuation procedures for residents requiring assistance. The individualized evacuation procedures were maintained electronically as part of the resident's care plan. These procedures were not readily available in the event of an emergency to all employees and emergency responders.

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

   Comments: The surveyor requested records for employee fire safety and evacuation plan training completed in 2025 and 2026, from the licensee. Documentation was provided for employee FSEP training completed on January 20, 2026. Employee FSEP training was not completed at the required frequency of at least twice per year.