Electronically Delivered

March 9, 2026

Licensee
Cedar Court
810 West Main Street
Adams, MN 55909

RE: Project Number(s) SL30231016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30231	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COURT	810 WEST MAIN STREET ADAMS, MN 55909

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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: SL30231016-0 On February 17, 2026, through February 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 33 residents; 28 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.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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	0 550		

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0 550	Continued From page 2 portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, the notice lacked the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health And Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On February 17, 2026, at 12:35 p.m., the surveyor observed the licensee's grievance procedure posted by a facility entrance. However, the posted information lacked the above content as required. On February 18, 2026, at 11:47 a.m., licensed assisted living director (LALD)-A stated the content noted above was not posted as required and was not aware it was missing from the posted grievance procedure. The licensee's Complaint/Grievance policy dated December 4, 2024, noted the written notice would include: - the name and contact information of the person representing the facility designated to handle and resolve complaints - the contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints.	0 550		

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0 550	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a two-step TST (tuberculin skin test) result in millimeters (mm) of induration for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 4 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: The facility's TB risk assessment was completed December 1, 2025, and was determined to be a low risk level. ULP-G began providing direct care services for the licensee on November 17, 2025. ULP-G's employee file included a TB history and symptom screen completed on December 9, 2025, and first step TST administered. The first step TST was read on December 11, 2025, and was documented as "negative;" however, it was not read in mm of induration. The second step TST was administered on December 31, 2025. The second step TST was read on January 2, 2025, (erroneously documented year as 2025, instead of 2026) and was documented as "negative;" however, it was not read in mm of induration. On February 19, 2026, at 11:54 a.m. during a phone interview, director of nursing (DON)-H stated first and second step TSTs need to be documented in mm of induration. "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, included TST documentation should include the date of the	0 660		

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0 660	Continued From page 5 test, the number of millimeters of induration (if no induration, document "0" mm) and interpretation (positive or negative). The licensee's TB Prevention and Control policy revised/reviewed October 26, 2022, noted TST documentation will include the date of the test, the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 6 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 730		

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0 730	Continued From page 7 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 began receiving services on July 29, 2025, and was discharged on October 30, 2025. R3's record lacked a discharge summary. On February 18, 2026, at 2:07 p.m., clinical nurse supervisor (CNS)-B stated a discharge summary had not been completed for R3. CNS-B indicated there was a different nurse working at the time and it had "fell through the cracks". The facility Discharge Summary policy dated December 30, 2024, noted a discharge summary would be written at the time of discharge and would include a summary of the resident's stay. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 8 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 17, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 9 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was developed to include all services the licensee provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on November 7, 2023, and had diagnoses including diabetes. On February 18, 2026, at 11:22 a.m., the surveyor observed unlicensed personnel (ULP)-F check R2's blood sugar and administer medications. R2's record lacked a written service plan documenting agreement on the services to be	01640		

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01640	Continued From page 10 provided. On February 19, 2026, at 1:11 p.m., licensed assisted living director (LALD)-A stated R2 lacked a service plan. LALD-A indicated R2 did not require services until early 2025, and there should have been a service plan developed at that time, but it was missed. The licensee's Contents of Service Plans policy dated revised/reviewed December 30, 2024, noted: 1. A finalized service plan will be completed no later than 14 calendar days after initiation of services. 2. Service plans and any revisions to service plans will have a signature or other authentication by the facility and the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 11 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-F) administered medications as prescribed. 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: R5's diagnoses included cerebral palsy (condition that affects movement and posture caused by brain damage before birth). R5's service plan dated August 11, 2025, noted services including medication administration. R5's prescriber orders dated February 9, 2026, included orders for: - Refresh (eye lubricant) instill one drop in both eyes four times daily for dry eyes. R5's medication administration record (MAR) dated February 1, 2026, through February 18, 2026, included the same order for Refresh eye drops, instill one drop in both eyes four times daily.	01760		

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01760	Continued From page 12 On February 18, 2026, at 12:12 p.m., the surveyor observed ULP-F prepare and administer medication to R5. ULP-F sanitized hands, applied gloves, and administered Refresh two drops to each eye. When interviewed at this time, ULP-F stated she administered two drops but should only have administered one drop to each eye. ULP-F further stated the prescriber's order was not followed. On February 18, 2026, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated staff should administer medications as prescribed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated reviewed December 18, 2024, noted medications always need to be administered according to the "6 Rights": e. Right dose (how many milligrams, drops, etc.) No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30231	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COURT	810 WEST MAIN STREET ADAMS, MN 55909

(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
02320	Continued From page 13 Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of three employees (unlicensed personnel (ULP)-E) and failed to ensure one of three employees (ULP-E) administered medications as prescribed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included chronic pain and muscle weakness. R4's service plan dated December 30, 2024, included medication administration. R4's prescriber orders dated July 2, 2025, included an order for diclofenac (topical gel to relieve pain, swelling, and stiffness in joints) 1% apply 1 gram to affected areas three times daily. R4's medication administration record (MAR) dated February 2025, included diclofenac 1% gel apply 1 gram to affected areas three times daily. On February 18, 2026, at 8:45 a.m., the surveyor observed ULP-E prepare and administer medications to R4. ULP-E reviewed R4's MAR, sanitized hands, donned clean gloves, and placed a dime sized amount of R4's diclofenac 1% gel to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30231	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COURT	810 WEST MAIN STREET ADAMS, MN 55909

(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
02320	Continued From page 14 her gloved hand. ULP-E then applied the diclofenac gel to R4's bilateral feet, toes, and ankles. ULP-E did not measure the amount of diclofenac gel applied. Following the application of the gel, ULP-E removed gloves, sanitized hands, and documented the diclofenac 1% gel administration. When interviewed at this time, ULP-E stated she was not sure how to measure 1 gram. In addition, the label on the diclofenac gel stated to apply to R4's bilateral legs. ULP-E stated she had never applied the gel to R4's legs only to her feet, toes, and ankles, indicating that is where R4 wanted it applied. On February 18, 2026, at 1:11 p.m., clinical nurse supervisor (CNS)-B stated staff were taught and instructed to use a dosing card measuring device that identifies grams for an accurate measurement of the medication. In addition, CNS-B stated staff should have followed the orders as reflected on MAR and medication label. CNS-B further stated she would expect staff to notify her if the resident wanted it applied to locations not identified on MAR or label. The diclofenac sodium instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. The licensee's Administration of Medication by Unlicensed Personnel policy dated reviewed December 18, 2024, noted medications always need to be administered according to the "6 Rights": e. Right dose (how many milligrams, drops, etc.) The licensee's Administration and Documentation of Routine Medications and PRN (as needed) Medications policy dated revised/reviewed December 18, 2024, included:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30231	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COURT	810 WEST MAIN STREET ADAMS, MN 55909

(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
02320	Continued From page 15 5. Staff will administer medications exactly as prescribed and will document administration of medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Cedar Court
810 West Main Street
adams, MN 55909
Mower County
Parcel:

Phone:
apeck@colonycourtmn.com

License Info

License: HFID 30231
Ashley Peck
Risk:
License:
Expires on:
CFPM: Jay
CFPM #: 55381; Exp: 1/20/2028

Inspection Info

Report Number: F1038261025
Inspection Type: Full - Single
Date: 2/18/2026 Time: 10:12:30 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

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 F1038261025 from 2/18/2026

Jay Scholljeyerdes
Kitchen Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30231016-0	**Date:** February 17, 2026
Facility Name: CEDAR COURT	
Facility Address: 810 WEST MAIN ST, ADAMS MN 55909	

☒ **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. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments: Unoccupied resident bedroom windows in apartments 601, 602, 603 and 604 measured 15.6" wide x 51" in height. The egress windows did not meet the minimum requirements for minimum opening width.