



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 23, 2026

Licensee

Nature's Point Assisted Living
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: Project Number(s) SL21937016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 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 . . ."

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 \$1,000.00**. 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.

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,

A handwritten signature in cursive script that reads "Kelly Thorson". The ink is dark and the signature is fluid.

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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: SL21937016-0 On August 24, 2026, through August 25, 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 thirty (30) residents; thirty (30) receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 August 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 480	Continued From page 3	0 480			
0 510 SS=D	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for administration of injections. This had the potential to affect all residents receiving blood glucose monitoring and injectable medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 510	Continued From page 4 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on August 15, 2024. R2 diagnoses included type 2 diabetes. R2's electronic medication administration record (EMAR) included the following orders - Toujeo SoloStar (a long-acting insulin used to control blood sugar) Subcutaneous Solution Pen-injector 300 UNIT/ML (Insulin Glargine) Inject 32 unit subcutaneously two times a day - NovoLOG ReliOn (a fast-acting insulin used to control blood sugar spikes that occur during meals with people with diabetes) Injection Solution 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously three times a day - Blood Glucose Checks- Update RN if blood glucose result is greater than 400 or lower than 70 four times a day - On August 25, 2026 at 7:05 a.m., surveyor observed unlicensed personnel (ULP)-E administer R2's morning medications, which included R2's insulin and blood sugar check. ULP-E prepared the insulin pens for administration by checking the EMAR, uncapping the pen, applying a needle (without cleaning the tip of the pen with an alcohol wipe), priming the needle with 2 units, and dialing up the correct dose of insulin. ULP-E proceeded to bring the medications into R2's apartment, check blood sugar via fingerstick with shared glucometer, and administered all medications. ULP-E brought the shared glucometer back to the medication cart and placed in a drawer without cleaning.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 510	Continued From page 5 ULP-E confirmed she did not clean the top of the insulin pens with an alcohol wipe prior to applying the needles. ULP-E stated this was her normal practice. ULP-E stated there is one glucometer that is shared between all of the resident's who receive blood sugar checks. ULP-E stated there are disinfecting wipes to clean the glucometer, however she did not usually clean it between residents. ULP-E stated she would clean the glucometer when she had free time during her shift. On August 25, 2026 at 8:45 a.m., clinical nurse supervisor (CNS)-B confirmed the facility currently shared one glucometer for everyone who required blood sugar monitoring and did not have another method. CNS-B stated all staff are trained to clean the glucometer between residents and this was important to prevent the spread of disease. CNS-B stated she watches a return demonstration with all new staff to ensure they are able to preform delegated tasks, including blood sugar checks and administration of insulin. Licensee policy for cleaning and disinfection of a glucometer dated May 8, 2024, included all glucometers shared between residents would be thoroughly wiped down according to manufacturer's recommendations and allowed to air dry after every use and between each resident. Licensee policy for insulin administration, undated, included to wipe down the rubber seal with an alcohol swab after removing the pen cap and before placing the needle. No further information was provided.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 510	Continued From page 6	0 510			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 680	Continued From page 7 all residents receiving services under the provisional assisted living license. 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: The licensee's undated EPP lacked the following required content: - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; On August 25, 2026, at 10:00 a.m., licensed assisted living director (LALD)-A stated he could not locate the patient population in the EPP binder, but he thought they had updated it at one point. The licensee's Emergency Preparedness policy dated May 13, 2023, indicated the licensee would have an emergency preparedness plan that would include all required elements and would utilize a hazard vulnerability analysis tool to measure threats and hazards. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types:	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
0 680	Continued From page 8 Interpretive Guidance. 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 775	Continued From page 9 days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 810	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty (21) days.	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 950	Continued From page 11 FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language in the Resident Agreement giving residents the right to identify a designated representative for thirty of thirty residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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 the potential to affect a large portion or all the residents). The findings include:	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
0 950	Continued From page 12 On August 24, 2026, at 10:11 a.m. licensed assisted living director (LALD)-A provided the Resident Agreement for all licensee's residents. The licensee's Resident Agreement lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On July 25, 2026, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated she was unaware of the required verbatim language and would fix it to meet the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for all licensee's residents.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 970	Continued From page 13 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 of the residents). The findings include: On August 24, 2026, at 10:11 a.m. licensed assisted living director (LALD)-A provided the Resident Agreement for all licensee's residents. The licensee's Resident Agreement, page 12 read, "(n) Indemnification. Resident will indemnify and hold harmless Community from all claims, expenses, and damages arising out of property damage or physical injury caused by Resident, Resident's guests or any third party hired by Resident, including repair or replacement of property of Community, its staff, or other residents, and injuries to Community's staff or other residents." On August 25, 2026, at 9:18 a.m., clinical nurse supervisor (CNS)-B stated they understood why the indemnification would not meet requirements and would fix to meet the requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
01290	Continued From page 14 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) 21937 for one of fifteen (15) employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
01290	Continued From page 15 During the entrance conference on August 24, 2026, at 9:08 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required content in an employee record. ULP-E was hired on July 28, 2026, to provide direct care to licensee's residents. On August 25, 2026 at 7:05 a.m., surveyor observed unlicensed personnel (ULP)-E administer R2's morning medications. ULP-E's employee record contained a cleared background study affiliated to the licensee's sister skilled nursing facility HFID 614 and not the licensee's HFID 21937. On August 25, 2026, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee's human resources office was responsible for completing employee background studies upon hire and would alert CNS-B once cleared to work. CNS-B further stated human resources (HR)-F was on vacation at the time that ULP-E was hired and stated the HR-F's assistant performed ULP-E's clearance. The licensee's Background Study policy dated May 30, 2023, read "Using the MN DHS NetStudy online program, the Facility will initiate a background study on all employees being considered for hire." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
01530	Continued From page 16	01530			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(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
01530	Continued From page 17 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 required two hours of initial mental illness and de-escalation training were conducted within 160 working hours of the employment start date for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on March 3, 2026, to provide direct care to licensee's residents. On August 25, 2026, at 7:59 a.m. surveyor reviewed ULP-D's employee record that lacked the required two hours of initial mental illness and de-escalation training. ULP-D's training record indicated one hour of de-escalation training was completed. On August 25, 2026, at 9:10 a.m. clinical nurse supervisor (CNS)-B verified one hour of de-escalation training was completed for ULP-D and lacked the required mental illness training.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(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
01530	Continued From page 18 CNS-B stated human resources (HR)-F oversees all employee training. On August 25, 2026, at 10:47 a.m. licensed assisted living director (LALD)-A state licensee did not have a policy or procedure for employee education on training for mental illness requirements. On August 25, 2026, at 10:58 a.m. (HR)-F stated they "oversee all employee education and was not aware of the required mental illness education." The licensee's Staff Training policy dated July 8, 2024, read "this policy is to provide an overview of the process for initial orientation and on-going in-service training based on the state and federal regulations and the needs of the residents served in the facility. Staff will be appropriately trained to improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 19 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instruction for each resident medication and documented those instructions in the resident's record and 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 August 15, 2024. R2 diagnoses included severe obesity and hypoxemia (low blood oxygen levels). R2's electronic medication administration record (EMAR) included Symbicort Inhalation Aerosol (a steroid inhaler) 80-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puffs. No further instructions were included.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 20 On August 25, 2026 at 7:05 a.m., surveyor observed unlicensed personnel (ULP)-E administer R2's morning medications, which included the Symbicort inhaler. ULP-E handed the inhaler to R2 to administer. R2 took two puffs of the inhaler a few seconds apart with mouth open, not breathing in while administering the medication or holding the medication in her lungs before breathing out. ULP-E did not advise R2 to close mouth around the inhaler, breathe in slowly, hold the medication prior to breathing out, or wait approximately a minute between puffs. ULP-E did not offer water to R2 or remind her to rinse her mouth after use of the inhaler. ULP-E stated she followed her normal process for administration of the inhaler. On August 25, 2026 at 8:45 a.m., clinical nurse supervisor (CNS)-B stated all staff are trained and competency tested for medication administration prior to administering medications independently. CNS-B confirmed R2 was receiving a Symbicort inhaler and should have had instructions to rinse mouth after use of the inhaler. Licensee's delegated duties competency training check off for ULP-E included administration of medication via and inhaler. Competency packet was signed by both ULP-E and CNS-B on August 11, 2026. Instructions for administration of medication via an inhaler include: - read specific instructions that come with the prescription of the medication - ask the resident to tilt his/her head back slightly and breathe out - ask the resident to breathe in slowly as the inhaler is pressed to release the medication and continue to breathe slowly for 3 to 5 seconds after	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER NATURE'S POINT ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 21 the medication has been released. Hold his/her breath for 10 seconds to allow the medication to go into the lungs and slowly exhale through the nose - if more than one puff is ordered, allow at least one minute between puffs to maximize the benefits of the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

NATURE'S POINT ASSISTED LIVING
1717 UNIVERSITY DRIVE SE
St Cloud, MN 56304
Sherburne County
Parcel:

Phone:
ajackson@edenbrookstcloud.com

License Info

License: HFID 21937

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

Inspection Info

Report Number: F1037261248
Inspection Type: Full - Single
Date: 8/24/2026 Time: 11:45:19 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision

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

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

COMMENT: ANTHONY HAD A FOOD SAFETY COURSE CERTIFICATE. AFTER TAKING AN APPROVED FOOD SAFETY MANAGER COURSE, SUBMIT THE EXAM RESULTS WITH THE STATE CERTIFIED FOOD PROTECTION MANAGER (CFPM) APPLICATION WITHIN 6 MONTHS OF THE EXAM DATE. POST THE STATE CFPM CERTIFICATE IN THE ESTABLISHMENT.

Comply By: 9/24/2026 Originally Issued On: 8/24/2026

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C3 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

COMMENT: PREVIOUS ORDER 7/22/24: QUATERNARY AMMONIUM SANITIZING SOLUTION IN THE WIPING CLOTH BUCKET MEASURED 0 PPM. MAINTAIN THE QUATERNARY AMMONIUM SANITIZING SOLUTION BETWEEN 200 AND 400 PPM.

8/24/26 WIPING CLOTH BUCKET SENT FROM SKILLED NURSING KITCHEN MEASURED 0 PPM AT THE TIME OF ARRIVAL. EMPLOYEE STATED THE SOLUTION WAS 200PPM IN THE KITCHEN PRIOR TO ADDING A TOWEL. DISCUSSED TESTING SOLUTION BEFORE AND AFTER ADDING A NEW, CLEAN TOWEL. IF THE ADDITION OF A TOWEL IS SIGNIFICANTLY CHANGING OR ELIMINATING YOUR SANITIZING SOLUTION CONCENTRATION, CONSIDER CHANGING MATERIAL OF YOUR WIPING CLOTH TOWELS. MAINTAIN THE QUATERNARY AMMONIUM SANITIZING SOLUTION AT A CONCENTRATION OF 200-400 PPM IN THE WIPING CLOTH BUCKETS.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 4-900 Protecting Clean Items

4-904.13 Priority Level: Priority 3 CFP#: 44

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

COMMENT: DINING AREA TABLEWARE WAS PRESET AND UNCOVERED IN UNMONITORED DINING AREA. SET TABLEWARE JUST PRIOR TO SERVICE AND REMOVE USED AND UNUSED TABLEWARE IMMEDIATELY FOLLOWING SERVICE, OR SET COVERED / WRAPPED TABLEWARE.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

Food & Beverage General Comment

DISCUSSED MENU, HIGH RISK FOODS, LEFTOVERS, BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, AND ORDERS. FOODS ARE PREPARED IN THE SKILLED NURSING KITCHEN AND SENT TO THE ASSISTED LIVING SERVING KITCHEN FOR IMMEDIATE SERVICE.

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

I acknowledge receipt of the St Cloud District Office inspection report number F1037261248 from 8/24/2026

ANTHONY JACKSON



Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

NATURE'S POINT ASSISTED LIVING
St Cloud
County/Group: Sherburne County

Inspection Info

Report Number: F1037261248
Inspection Type: Full
Date: 8/24/2026
Time: 11:45:19 AM

Food Temperature: **Product/Item/Unit:** CARROTS; **Temperature Process:** Receiving

Location: Steam Table at 173 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** NOODLES; **Temperature Process:** Receiving

Location: Steam Table at 137 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BEEF STROGANOFF; **Temperature Process:** Receiving

Location: Steam Table at 179 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** PUREE VEGETABLE; **Temperature Process:** Receiving

Location: Steam Table at 143 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SOFT BITE BEEF; **Temperature Process:** Receiving

Location: Steam Table at 137 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

NATURE'S POINT ASSISTED LIVING
St Cloud
County/Group: Sherburne County

Inspection Info

Report Number: F1037261248
Inspection Type: Full
Date: 8/24/2026
Time: 11:45:19 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 200 PPM

Comment: REFILL, NO TOWEL

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1037261248		Food Establishment Inspection Report		Page 1 of 1		
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		2	Date: 8/24/2026	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:45:19 AM	
		Score (optional)			Dur: min	
Establishment: NATURE'S POINT ASSISTED LIVING		Address: 1717 UNIVERSITY DRIVE SE		City/State: St Cloud, MN	Zip: 56304	Phone:
License/Permit #: HFID 21937		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable						
Mark "X" in appropriate box for COS and/or R						
COS=corrected on-site during inspection R=repeat violation						
Compliance Status			COS	R		
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	OUT	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	IN	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	N/A	Food separated and protected				
16	OUT	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
Compliance Status			COS	R		
Safe Food and Water						
30	N/A	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	N/O	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature) <i>Michael J. Aronow</i>						
Follow-up: Follow-up Date:						
Time/Temperature Control for Safety						
18	N/O	Proper cooking time & temperatures				
19	N/O	Proper reheating procedures for hot holding				
20	N/O	Proper cooling time and temperature				
21	N/O	Proper hot holding temperatures				
22	IN	Proper cold holding temperatures				
23	N/O	Proper date marking & disposition				
24	N/A	Time as public health control; procedures & record				
Consumer Advisory						
25	N/A	Consumer advisory provided for raw or undercooked foods				
Highly Susceptible Populations						
26	IN	Pasteurized foods used; prohibited foods not offered				
Food/Color Additives and Toxic Substances						
27	N/A	Food additives; approved & properly used				
28	IN	Toxic substances properly identified; stored; used				
Conformance with Approved Procedures						
29	N/A	Compliance with variance, specialized processes & HACCP plan				
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury						

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL21937016-0	Date: 8/24/2026
Facility Name: NATURE'S POINT ASSISTED LIVING	
Facility Address: 1717 University Dr SE, St Cloud, MN 56304	

☒ 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. In buildings protected by automatic sprinklers or automatic fire detectors, suspended or removable ceiling tiles shall be maintained in place to prevent the delay in sprinkler or detector activation. [Minn. Stat. 144G.45 subd. 2; MSFC 901.11]

Comments: Surveyor observed missing ceiling tiles in Storage Room 10, resulting in openings in the ceiling and exposing the space above. The missing ceiling tiles compromised the integrity of the ceiling assembly and could allow smoke and fire to spread into concealed spaces.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The licensee failed to maintain the emergency egress route free from obstructions. A bed frame completely blocked the emergency egress door in the east-side stairwell, preventing the door from being readily accessible for emergency evacuation. Licensed Assisted Living Director (LALD)-A removed the bed frame after the deficiency was identified.

4. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: The licensee failed to ensure smoking materials were properly discarded to prevent the potential ignition of combustible materials. Discarded cigarette butts were located around the exterior maintenance/laundry room doors and near the northeast-side entrance of the facility.

5. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

Comments: Open electrical junction boxes were located in various areas throughout the facility, leaving electrical wiring and connections exposed and creating a potential electrical and fire hazard.

6. Fire protection equipment shall be identified in an *approved* manner. Rooms containing controls for air-conditioning systems, sprinkler risers and valves, or other fire detection, suppression or control elements shall be identified for the use of the fire department. *Approved* signs required to identify fire protection equipment and equipment location shall be constructed of durable materials, permanently installed and readily visible. [Minn. Stat. 144G.45 subd. 2; MSFC 509.1]

Comments: Access doors to the sprinkler riser rooms were not labeled with approved signage identifying the location of the sprinkler system risers, which could delay identification and access to fire protection equipment during an emergency.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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: Surveyor requested the FSEP for review. During review licensed assisted living director (LALD)-A stated the resident plan was located inside the resident's individual folders. The licensee was able to provide a copy via email. FSEP for residents should always be readily available.