Electronically Delivered

July 31, 2026

Licensee
Getty Street Assisted Living
1214 Getty Street South
Sauk Centre, MN 56378

RE: Project Number(s) SL30493016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 8, 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:

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
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 $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jessica Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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: SL30493016-0 On July 6, 2026, through July 8, 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 24 residents; all 24 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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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		

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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 July 6, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	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 infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three employees (licensed practical nurse/LPN-C). This had the potential to affect all the licensee's 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 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).	0 510		

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0 510	Continued From page 4 The findings include: On July 7, 2026, at 8:20 a.m., the surveyor observed LPN-C and unlicensed personnel (ULP)-H assist R1 with morning cares. With gloved hands, LPN-C performed perineal cares on R1, assisted to transfer R1 to the wheelchair, removed the gloves, touched the wheelchair, and pushed R1 to the dining room in the wheelchair, and then performed hand hygiene. Upon leaving the area, LPN-C stated hand hygiene should have been completed after performing perineal cares and removing the gloves, but no sanitizer was available in the bathroom and she did not bring her pocket size sanitizer with to R1's room. On July 8, 2026, at 11:37 a.m., clinical nurse supervisor (CNS)-A stated staff are expected to perform hand hygiene after perineal cares are completed and after gloves are removed. In addition, CNS-A stated staff had been provided small hand sanitizer bottles to carry with them at all times. The licensee's Handwashing policy dated July 20, 2023, noted hands should be washed or decontaminated before and after direct contact with a resident and after removing gloves. The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same	0 510		

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0 510	Continued From page 5 patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment 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, the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect the	0 550		

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0 550	Continued From page 6 licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 6, 2026, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the building to be one level with a main entrance, sitting area, dining room, kitchen, sunroom, and resident rooms. Postings were located in the dining room. The posted Complaint Policy and Procedure dated August 26, 2022, lacked the name, telephone number, and email contact information for LALD-B, who was identified to be the individual responsible for handling complaints. On July 6, 2026, at 1:25 p.m., LALD-B stated the posted complaint policy lacked the contact information as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640		

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0 640	Continued From page 7 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 6, 2026, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the building to be a one level building with a main entrance, sitting area, dining room, kitchen, sunroom, and resident rooms. Postings were located in the	0 640		

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0 640	Continued From page 8 dining room. On July 6, 2026, at 1:25 p.m., LALD-B stated the 911 emergency number was not posted in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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.	0 680		

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0 680	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 6, 2026, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the building to be a one level building with the main entrance, sitting area, dining room, kitchen, sunroom, and resident rooms. The licensee's red binder labeled Emergency Preparedness Manual was stamped as reviewed November 25, 2025, by LALD-B and December 31, 2025, by administrative assistant (AA)-E. The EPP lacked the following required content: - alternate sources of energy to maintain safe and sanitary storage of provisions and sewage and waste control; - policy and procedure to include a system to tract the location of on-duty staff;	0 680		

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0 680	Continued From page 10 - policy and procedure to address the use of volunteers, including the process for integration; and - policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. On July 8, 2026, at 1:25 p.m., LALD-B stated the above required content was not included in their emergency preparedness plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 11 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 730		

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0 730	Continued From page 12 has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's record lacked a discharge summary with a summary of the resident's stay that included: - course of illnesses; - treatments and therapies; - pertinent lab, radiology and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current medical, behavioral, and functional status. R3's diagnoses included hypothyroidism (under active thyroid), and dementia (a progressive disease causing cognitive decline). R3 admitted to the facility on August 19, 2025, and discharged to another facility on April 7, 2026. R3's service plan dated March 27, 2026, indicated R3 received services including assistance with bathing, dressing, and toileting. R3's progress note dated April 7, 2026, noted R3 discharged to a memory care community and the face sheet and care plan were sent along. On July 8, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated they send documentation including the latest history and physical, face sheet, and care plan along with the resident, but do not do a discharge summary including the above required information. The licensee's Discharge Summary policy dated	0 730		

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0 730	Continued From page 13 August 26, 2022, noted the discharge summary would include a summary of the resident's stay including course of illnesses, treatments, therapies, pertinent lab, radiology and consultation reports, and a final summary of the resident's status. No further information was provided. TIME PERIOD FOR CORRECTIONS: 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 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:	0 775		

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0 775	Continued From page 14 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 07, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) 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	0 810		

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0 810	Continued From page 15 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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 July 07, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 16 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 17 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R1) who was hospitalized. 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: R1's diagnoses included prostate cancer, type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), and dementia (a progressive disease causing cognitive decline). R1's service plan dated July 1, 2026, indicated R1 received services including assistance with bathing, dressing, eating, and toileting. R1's progress notes indicated R1 was hospitalized April 28, 2026, through May 11, 2026. On July 8, 2026, at 12:08 p.m., clinical nurse supervisor (CNS)-A stated the licensee had not been completing an emergency relocation with	01060		

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01060	Continued From page 18 the required content for residents hospitalized. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with their health facility identification (HFID) for one of four employees (unlicensed personnel/ULP-D).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	01290		

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01290	Continued From page 19 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was aware of the required contents of an employee records. ULP-D was hired on March 18, 2019, to provide direct care services to residents. ULP-D's record included a background study clearance letter dated March 18, 2019, submitted through a previous HFID number associated with the licensee. On July 6, 2026, at 12:58 a.m., administrative assistant (AA)-H stated she was responsible for the background studies completed for the licensee's employees and stated ULP-H had not been affiliated with the licensee's current HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 20 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01440		

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01440	Continued From page 21 situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was aware of the required contents of an employee record. ULP-F was hired on September 10, 2025, to provide direct care services to the licensee's residents. ULP-F's record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On July 8, 2026, at 1:15 p.m., CNS-A stated a 30-day supervision had not been completed for ULP-F as required. The licensee's Supervision of Unlicensed Personnel policy dated August 26, 2022, noted direct supervision of unlicensed personnel performing delegate tasks must be performed within 30 days after the person has been determined competent to perform all tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470		

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01470	Continued From page 22 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470		

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01470	Continued From page 23 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (unlicensed personnel/ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A	01470		

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01470	Continued From page 24 stated the licensee was aware of the required contents of an employee records. ULP-F was hired on September 10, 2025, to provide direct care services to the licensee's residents. ULP-F's record lacked documented evidence of the following: - handling of resident complaints, reporting of complaints, where to report complaints; and - review of the types of assisted living services the employee would provide and provider's scope of license. On July 8, 2026, at 1:15 p.m., CNS-A stated she was unable to state whether ULP-F had received the above required orientation. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated August 26, 2022, noted all staff must receive orientation to assisted living licensing requirements prior to providing services to residents including the complaint process and the types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) and the scope of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 25 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 26 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (housekeeper/unlicensed personnel (H/ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was aware of the required contents of an employee record.	01500		

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01500	Continued From page 27 H/ULP-G was hired on September 14, 2017, to provide direct care services to the licensee's residents and to provide housekeeping services. Throughout the survey, the surveyor observed H/ULP-G interacting with the licensee's residents. H/ULP-G's record included a transcript of training completed with dates ranging from November 16, 2018, through January 5, 2026. However, it lacked documented evidence of annual training including: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On July 8, 2026, at 1:10 p.m., CNS-A stated the above training had not been completed annually as required. The licensee's Annual Training policy dated August 26, 2022, noted employees would complete annual training including effective approaches for communication with residents with dementia, Alzheimer's disease, or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 28 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 topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel/ULP-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was aware of the required contents of an employee record. ULP-F was hired on September 10, 2025, to provide direct care services to the licensee's residents. ULP-F's record lacked contained a transcript of education dated September 10-16, 2026, which included 7.5 hours dementia care training. However, it was short of the required 8.0 hours of dementia training. On July 8, 2026, at 1:15 p.m., CNS-A and administrative assistant (AA)-E stated the correct amount of dementia training must not have been	01530		

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01530	Continued From page 30 assigned to ULP-F. They stated ULP-F reached 160 working hours on October 20, 2025. The licensee's Dementia Training policy dated August 26, 2022, noted direct-care staff would complete a minimum eight hours initial training on dementia care topics within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01565 SS=C	144G.64 (c) Training in Dementia, Mental Illness, and De- (a)The facility shall provide to consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that will cause only 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	01565		

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01565	Continued From page 31 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living license effective December 1, 2025, through November 30, 2026. The licensee's undated Dementia Training Disclosure lacked the basic topics covered to include: - person-centered planning and service delivery; - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting crisis response teams and 988 suicide and crisis lifelines. On July 8, 2026, at 11:55 a.m., clinical nurse supervisor (CNS)-A stated the disclosure lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01565		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

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01620	Continued From page 32 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 33 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool for two of two residents (R1, 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 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: R1 and R2's records lacked the following required elements of the uniform assessment tool: - the resident's personal lifestyle preferences, including: - sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; and - advance health care directives and end-of-life preferences, including whether a	01620		

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01620	Continued From page 34 person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. - activities of daily living, including ambulation; - instrumental activities of daily living, including; - ability to self manage medications. - physical health status, including: - a review of relevant health history and current health conditions, including medical and nursing diagnoses; - allergies and sensitivities related to medication, seasonality, environment, and food and if of the allergies or sensitivities are life threatening; - infectious conditions; - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - the dosage; - the frequency of use; - the route administered or taken; - any difficulties the resident faces in taking the medication; - whether the resident self administers the medication; - the resident's preferences in how to take medication; - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and - provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's	01620		

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01620	Continued From page 35 medications and prevent diversion of medications. - a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility; - a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; - weight; and - initial vital signs if indicated by health conditions or medications; - emotional and mental health conditions, including: - review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder and thought disorders; - current symptoms of mental health conditions; - effective medication treatment and non-medication interventions; - cognition, including: - a review of any neurocognitive evaluations and diagnoses; - current memory, orientation, and decision-making status and ability; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - risk factors, including; - complex medication regimen; - risk for dehydration, including history of urinary tract infection and current fluid intake pattern; - risk of emotional or psychological distress due to personal losses; - unsuccessful prior placements; - elopement risk including history or previous	01620		

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01620	Continued From page 36 elopements; - smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property, and - alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; - who has decision-making authority for the resident, including; - the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and - the scope of decision-making authority of a substitute decision maker under subitem(1); and - the need for follow-up referrals for additional medical or cognitive care by health professionals. R1 R1's diagnoses included prostate cancer, type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), and dementia (a progressive disease causing cognitive decline). On July 7, 2026, at 8:20 a.m., the surveyor observed licensed practical nurse (LPN)-C provide morning cares to R1. R1's service plan dated July 1, 2026, indicated R1 received services including assistance with bathing, dressing, eating, and toileting. R1's record contained an assessment dated June 1, 2026, that lacked the above elements of the universal assessment tool. R2 R2's diagnoses included blindness in the left eye, type II diabetes, and hypertension (high blood pressure).	01620		

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01620	Continued From page 37 On July 7, 2026, at 9:35 a.m., the surveyor observed LPN-C administer insulin to R2. R2's service plan dated July 1, 2026, indicated R2 received services including assistance with bathing, dressing, medication administration, and catheter care. R2's record contained an assessment dated June 10, 2026, that lacked the above elements of the universal assessment tool. On July 8, 2026, at 12:08 p.m., clinical nurse supervisor (CNS)-A stated the same assessment template is utilized for all residents, and it does not include all elements of the uniform assessment tool. The licensee's Initial and On-going Nursing Assessment of Residents policy dated May 29, 2024, noted the comprehensive assessment would include the requirements outlined by the Minnesota rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	01650		

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01650	Continued From page 38 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, 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 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).	01650		

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01650	Continued From page 39 The findings include: R1 R1's diagnoses included prostate cancer, type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), and dementia (a progressive disease causing cognitive decline). On July 7, 2026, at 8:20 a.m., the surveyor observed licensed practical nurse (LPN)-C provide morning cares to R1. R1's service plan dated July 1, 2026, indicated R1 received services including assistance with bathing, dressing, eating, and toileting. However, it lacked: - the methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. R2 R2's diagnoses included blindness in the left eye, type II diabetes, and hypertension (high blood pressure). On July 7, 2026, at 9:35 a.m., the surveyor observed LPN-C administer insulin to R2. R2's service plan dated July 1, 2026, indicated R2 received services including assistance with bathing, dressing, medication administration, and catheter care. However, it lacked: - the methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On July 8, 2026, at 1:00 p.m., clinical nurse	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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
01650	Continued From page 40 supervisor (CNS)-A stated the licensee's service plan lacked the above required content, and added the same template was utilized for all residents. The licensee's Contents of Service Plans policy dated May 24, 2024, noted the service plan would include the schedule and methods of monitoring assessments and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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
01690	Continued From page 41 errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. The licensee's provided policies lacked:	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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
01690	Continued From page 42 - monitoring and evaluation of medication use. On July 8, 2026, at 11:40 a.m., CNS-A stated she was unable to locate a policy with the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse,	01700		

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	30493	A. BUILDING: _____ B. WING _____	07/08/2026

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GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

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01700	Continued From page 43 theft, or illegal or improper disposition of medications. 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) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for two of two residents (R1, 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 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: During the entrance conference on July 6, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. R1 R1's diagnoses included prostate cancer, type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), and dementia (a progressive disease causing cognitive decline). On July 7, 2026, at 8:20 a.m., the surveyor observed licensed practical nurse (LPN)-C	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30493	A. BUILDING: _____ B. WING _____	07/08/2026

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GETTY STREET ASSISTED LIVING	1214 GETTY STREET SOUTH SAUK CENTRE, MN 56378

(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
01700	Continued From page 44 provide morning cares to R1. R1's service plan dated July 1, 2026, indicated R1 received services including assistance with bathing, dressing, eating, and toileting. R1's Medication Administration Record (MAR) for July 2026, included the names and dosage of medications, times to administer, and staff initials indicating the medications had been administered. R1's record lacked a medication assessment including: - an identification and review of all medications the resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. R2 R2's diagnoses included blindness in the left eye, type II diabetes, and hypertension (high blood pressure). On July 7, 2026, at 9:35 a.m., the surveyor observed LPN-C administer insulin to R2. R2's service plan dated July 1, 2026, indicated R2 received services including assistance with bathing, dressing, medication administration, and catheter care. R2's MAR for July 2026, included the names and dosage of medications, times to administer, and staff initials indicating the medications had been administered.	01700		

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01700	Continued From page 45 R2's record lacked a medication assessment including: - an identification and review of all medications the resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On July 8, 2026, at 12:08 p.m., clinical nurse supervisor CNS-A stated she reviewed the medications with the residents and completed a medication reconciliation, but it did not include the above required information. The licensee's Medication Assessment policy dated May 29, 2024, noted the medication assessment would include the identification of all known medications the resident was taking, a review of the side effects, contraindications, allergies, adverse reactions, and interventions to prevent medication diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication	01780		

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01780	Continued From page 46 management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures with the required content for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 26, 2022, lacked statements to include: - for planned time away, the medications must be	01780		

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	30493	A. BUILDING: _____ B. WING _____	07/08/2026

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01780	Continued From page 47 obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; and - for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. On July 8, 2026, at 11:50 a.m., CNS-A stated the policy did not include the above required verbiage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed	01790		

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01790	Continued From page 48 nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility,	01790		

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01790	Continued From page 49 including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on July 6, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy and procedures dated August 26, 2022, lacked written procedures including: - how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01790	Continued From page 50 medication. On July 8, 2026, at 11:50 a.m., CNS-A stated the policy did not include the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN).	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01930	Continued From page 51 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 6, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided treatment management services to the licensee's residents. The licensee's provided policies lacked: - monitoring and evaluation of treatment or therapy. On July 8, 2026, at 11:40 a.m., CNS-A stated she was unable to locate a policy with the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		

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

Food & Beverage Inspection Report

Establishment Info

GETTY STREET ASSISTED LIVING
1214 Getty St S
Sauk Centre, MN 55303
Stearns County
Parcel:

Phone:
harry.maron@gettystreetassistedliving.com

License Info

License: HFID 30493

Risk:
License:
Expires on:
CFPM: Karyn Nelson
CFPM #: 63924; Exp: 11/2/2028

Inspection Info

Report Number: F7930261161
Inspection Type: Full - Single
Date: 7/6/2026 Time: 11:18:11 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: THE FOLLOWING PIECES OF EQUIPMENT ARE NOT ANSI APPROVED AND MUST BE REMOVED FROM THE ESTABLISHMENT: CROCKPOTS, WAFFLE MAKER AND ELECTRIC FRYING PAN.
Comply By: 7/6/2026 Originally Issued On: 7/6/2026

Food & Beverage General Comment

DISCUSSION ITEMS:
EMPLOYEE ILLNESS LOG, TEMPERATURE LOGS AND DISHWASHER FINAL RINSE CYCLE TESTING AND LOGS.

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 F7930261161 from 7/6/2026

Establishment Representative

Tina Remmele

Tina Remmele,
Public Health Sanitarian 3
320-223-7302
tina.remmele@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

GETTY STREET ASSISTED LIVING
Sauk Centre
County/Group: Stearns County

Inspection Info

Report Number: F7930261161
Inspection Type: Full
Date: 7/6/2026
Time: 11:18:11 AM

New Record: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler--SINGLE DOOR COOLER IN DRY STORAGE ROOM at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** SLICED HAM**; Temperature Process:** Cold-Holding
Location: Upright Cooler--2 DOOR UNIT IN KITCHEN at 39 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

Establishment Info

GETTY STREET ASSISTED LIVING
Sauk Centre
County/Group: Stearns County

Inspection Info

Report Number: F7930261161
Inspection Type: Full
Date: 7/6/2026
Time: 11:18:11 AM

New Record: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To**
Comment: 169.6 DEG F
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30493016	**Date:** 7/7/2026
Facility Name: Getty Street Assisted Living	
Facility Address: 1214 Getty Street South S. Sauk Centre, MN 56378	

☒ **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. Gates used as a component in a means of egress shall meet the same requirements for doors. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2; MSFC 1010.1.9]

   Comments: The emergency exit doors in the sunroom lead into a fenced courtyard. The courtyard exits had a lock that required a key to unlock each gate. Licensed assisted living director (LALD)-B stated that the gates were not tied in to the building's fire alarm system and would not unlock during a fire or other emergency.

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: This FSEP that was provided by the licensed assisted living director (LALD)-B did not have specific actions for the employees at this facility. The policy included general information for

staff during an evacuation but was not specific to the facility's layout or construction. The policy referenced smoke compartments which were not identified on the egress maps, and it also included a section that indicated the memory care area was unattended. This facility does not have a memory care unit.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. .

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency, including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.

4. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Fire safety and Evacuation drills were conducted every three months. LALD-B stated that the fire drills were being done quarterly, and they were not aware of the requirements.