Electronically Delivered

July 2, 2026

Licensee
Vista At Pine Haven
220 3rd Street Northwest
Pine Island, MN 55963

RE: Project Number(s) SL30468016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 10, 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.

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:

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
1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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 COMMENT SL30468016-0 On June 8, 2026, through June 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider as a result of a Change of Ownership (CHOW), and the following correction orders are issued. At the time of the survey, there were 21 residents; 15 receiving services under the Assisted Living Facility license. 1760: An immediate order was issued on June 9, 2026, at a level three/Isolated (G). The licensee took immediate action; however, the scope and level remains at G.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 8, 2026, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a Health Service Executive license effective through June 30, 2027; however, LALD-A license lacked an organization listed as the Director of Record for the licensee. On June 8, 2026, at 6:37 a.m., the evaluator emailed a BELTSS representative to clarify LALD-A's status as director of record for the facility. At 5:28 p.m., the BELTSS representative	0 110		

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0 110	Continued From page 2 stated LALD-A was not listed as Director of Record for the licensee. On June 9, 2026, at 9:45 a.m., LALD-A reviewed the BELTSS website and stated she was not listed as the Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 3 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 8, 2026, at 9:30 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee had not created or implemented a QMP. The licensee's Quality Management Project policy dated September 1, 2025, indicated the facility would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 4 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on March 28, 2024, with diagnoses that included diabetes. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's IAPP (found within the comprehensive nursing assessment) dated May 20, 2026, did not include the following required items: - the resident's risk of abusing other vulnerable adults; - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 5 On June 10, 2026, at 11:51 a.m., clinical nurse supervisor (CNS)-B stated R2's IAPP did not include R2's risk of abusing other vulnerable adults and specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The licensee's Individual Abuse Prevention Plan policy dated September 1, 2025, indicate the facility will develop and implement an individual abuse prevention plan for each vulnerable adult. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: -other vulnerable adults -the person's risk of abusing other vulnerable adults, and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults For purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 6 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a current facility TB risk assessment. In addition, the licensee failed to document a completed health history and symptom screening and complete a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did no harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: TB FACILITY RISK ASSESSMENT On June 8, 2026, at approximately 9:30 a.m. during the entrance conference the surveyor requested to review the licensee's TB Facility Risk Assessment.	0 660		

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0 660	Continued From page 7 On June 10, 2026, at 11:17 a.m., clinical nurse supervisor (CNS)-B stated she could not locate a TB facility Risk assessment and would complete one today. EMPLOYEE SCREENING ULP-D was hired on June 23, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of a TB history and symptom screening and documentation of a two-step TST or other evidence of TB screening such as a blood test. On June 10, 2026, at 11:20 a.m., CNS-B stated ULP-D's record lacked documentation of TB history and symptom screening and TST or other evidence of TB screening such as a blood test. The licensee's Tuberculosis Surveillance and Control policy dated July 13, 2025, indicated the following: -the facility will conduct an evaluation of the risk for transmission of M. tuberculosis in their facility to determine the controls needed in their facility-specific TB Control Plan as applicable to state rules and statues. -guidelines for screening is applicable to all residents new to the facility, all employees of facility, consultants or temporary agency, respite residents, adult day services, participates and volunteers if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 8	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan dated February 2024, lacked evidence of the following required content: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans); - arrangements/contracts to re-establish utility services; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures based on the EP, risk assessment and communication plan; - Policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - Policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents;	0 680		

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0 680	Continued From page 10 - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles; and - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from	0 680		

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0 680	Continued From page 11 engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On June 10, 2026, at 1:20 p.m., licensed assisted living director (LALD)-A stated licensee's current EP plan did not include the above required content. LALD-A stated the licensee was in the process of updating the EP plan. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
0 730	Continued From page 12 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 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 include the required content in a discharge summary for one of one discharged	0 730		

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0 730	Continued From page 13 resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on March 31, 2022, and discharged to another facility on March 9, 2026. R4's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and non-medical	0 730		

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0 730	Continued From page 14 services the resident will need. On June 10, 2026, at 11:54 a.m., clinical nurse supervisor (CNS)-B stated R4's record lacked a discharge summary. CNS-B stated she is aware of the discharge summary requirement, however, must have missed completing one for R4. The licensee's Discharge Summary policy dated September 1, 2025, indicated the facility shall prepare a written discharge summary for all residents discharged from the assisted living community. The discharge summary shall accurately reflect the resident's condition at discharge and include information necessary to ensure safe and effective continuation of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota 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	0 775		

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0 775	Continued From page 15 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 June 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; 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	0 790		

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0 790	Continued From page 16 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 810		

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0 810	Continued From page 17 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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).	0 810		

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0 810	Continued From page 18 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
01290 SS=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 a background study was affiliated with the assisted living facility (ALF) license for one of two employees (unlicensed personnel (ULP)-D).	01290		

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01290	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 23, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record contained a Background Study Clearance dated June 10, 2025, from a sister facility. However, ULP-D was not affiliated with the facility's license. On June 10, 2026, at 9:45 a.m., licensed assisted living director (LALD)-A stated ULP-D's background study was not affiliated to the facility's license. The licensee's Background Studies policy dated September 1, 2025, indicated the facility would conduct a background study on all employees and volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	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 20 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 21 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for two of two residents (R1 and 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) 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: R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration, diabetic management (including glucometer checks, insulin administration, coordination with provider as needed).	01620		

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01620	Continued From page 22 R1's ongoing nursing assessments dated September 16, 2025, December 15, 2025, and May 13, 2026, were reviewed. The December 15, 2025, assessment was completed 112 days after the date of the previous assessment, and the May 13, 2026, assessment was completed 127 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on March 28, 2024, with diagnoses that included diabetes. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's ongoing nursing assessments dated September 25, 2025, December 31, 2025, and May 20, 2026, were reviewed. The December 31, 2025, assessment was completed 102 days after the date of the previous assessment, and the May 20, 2026, assessment was completed 137 days after the date of the previous assessment, thus exceeding 90 calendar days. On June 10, 2026, at 12:02 p.m., clinical nurse supervisor (CNS)-B stated the electronic health system the licensee used was not triggering assessment due dates which caused the R1 and R2's assessments to be completed late. CNS-B stated this error has been fixed. The licensee's Assessments, Reviews and Monitoring policy dated September 1, 2025, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	01620		

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01620	Continued From page 23 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 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	01650		

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01650	Continued From page 24 by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1 and 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) 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: R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration, diabetic management (including glucometer checks, insulin administration, coordination with provider as needed). R1's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 25 emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in and emergency; and 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. R2 R2 was admitted on March 28, 2024, with diagnoses that included diabetes. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and 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.	01650		

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01650	Continued From page 26 On June 10, 2026, at 12:03 p.m., licensed assisted living director (LALD)-A reviewed R1 and R2's service plans and stated they did not include the required content as listed above. LALD-A further stated the same service plan was used for all residents. The licensee's Service Plan policy dated September 1, 2025, indicated the service plan would include following: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing the services e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: a. Acton's the facility will take if scheduled services cannot be provided b. Information regarding how the resident can contact the facility c. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition d. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency e. How the facility will support documented resident health care directive decisions, if any-including circumstances when emergency medication services are not to be summoned	01650		

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	30468	A. BUILDING: _____ B. WING _____	06/10/2026

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01650	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 a face-to-face medication management reassessment at least annually for two of two residents (R1 and R2) who received medication management services. In addition, the licensee failed to ensure two of two residents (R1 and R2) who self-administered medications were assessed for self-administration of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01710		

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01710	Continued From page 28 a large portion or all of the residents). The findings include: During the entrance conference on June 8, 2026, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents. R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. On June 9, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration, diabetic management (including glucometer checks, insulin administration, coordination with provider as needed). R1's record contained an Individualized Medication Management Plan dated May 13, 2026, and a Medication Self-Administration Safety Screen Assessment dated May 13, 2026. R1's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R2	01710		

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01710	Continued From page 29 R2 was admitted on March 28, 2024, with diagnoses that included diabetes. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's record contained an Individualized Medication Management Plan dated May 20, 2026, and a Medication Self-Administration Safety Screen Assessment dated June 2, 2026. R2's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On June 10, 2026, at 12:09 p.m., CNS-B stated R1 and R2's medication management assessments had not been reassessed as required. CNS-B stated she was not aware that reassessment was required as needed, and at minimum, annually. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated September 1, 2025, indicated "[Licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. Also, included "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment	01710		

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01710	Continued From page 30 must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) 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. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." SELF-ADMINISTRATION OF MEDICATIONS R1 R1's medication administration record (MAR) dated June 2026, included the following: -Dextrose oral gel 40%; give 15 grams by mouth as needed for hypoglycemia (low blood sugar) unsupervised self-administration. Okay to keep at bedside for self-administration. -Glucose tablet 4 grams; chew one tablet by mouth as needed for low blood sugar. Please leave 3-5 tablets in resident room for her to utilize in the event of hypoglycemia. R1's Medication Self-Administration Safety Screen Assessment dated May 13, 2026, indicated the following: -List of all medications that are being considered	01710		

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01710	Continued From page 31 for resident to self administer: polyethylene glycol powder, fluticasone propionate nasal spray, Humalog Junior Kwik Pen, and Insulin Degludec pen. -Review Summary: The resident is able to self-administer insulin after the staff verifies the insulin dosing. The resident may self-administer Miralax (polyethylene glycol) and Flonase (fluticasone propionate) unsupervised. R1's medication self-administration assessment did not assess R1's ability to self-administer PRN (as needed) Dextrose oral gel and glucose tablets for low blood sugar. R2 R2's MAR dated June 2026, included the following: -polyethylene glycol powder; give 17 grams by mouth one time a day for constipation -Novolin insulin Flex pen; inject 45 units subcutaneously one time a day On June 9, 2026, at 6:43 a.m., the surveyor observed ULP-C prepare R2's medications and insulin for administration. During the preparation of medications, ULP-C stated R2 self-administered polyethylene glycol and then documented it as administered even though ULP-C did not administer the medication. ULP-C prepared the rest of R2's medications and brought them to R2's apartment. Prior to administering R2's insulin, ULP-C asked R2 if he was going to administer the insulin or if he wanted her to administer it. R2 stated ULP-C could administer it. ULP-C administered R2's insulin as prescribed and administered R2's oral medications. At this time, the surveyor observed one bottle of medication on R2's desk and one inhaler, one nasal spray and one bottle of	01710		

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01710	Continued From page 32 medication on R2's bedside table. ULP-C returned to the medication cart and documented administration of R2's medications and insulin. The surveyor inquired if R2 self-administered his insulin at times. ULP-C stated R2 used to self-administer his insulin most days but recently stated when his fingers felt numb he would have the ULP administer the insulin. ULP-C stated R2 self-administered the medications on his desk and bedside table. On June 9, 2026, at 7:32 a.m., R2 stated he liked to self-administer his own insulin; however, the numbness in his fingers had recently gotten worse and had the ULP administer the insulin most days. R2 stated the medication bottle on his desk and bedside table were supplements and declined to allow the surveyor look at the bottles. R2 stated self-administered supplements and his nasal spray, inhaler, and topical creams. R2's Medication Self-Administration Safety Screen Assessment dated June 2, 2026, indicated the following: -List of all medications that are being considered for resident to self administer: clotrimazole external cream and Testosterone Transdermal gel. -Review Summary: Resident may self-administer topical creams without supervision. R2's medication self-administration assessment did not assess R2's ability to self-administer polyethylene glycol, insulin, nasal spray, inhaler and supplements. On June 10, 2026, at 12:15 p.m., CNS-B stated R1's self-administration of medications assessment did not include PRN Dextrose gel or glucose tablets. CNS-B stated she was not aware	01710		

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01710	Continued From page 33 that R2 was self-administering his polyethylene glycol or his insulin. CNS-B stated she was not aware that R2 was self-administering other supplements, an inhaler, and nasal spray. CNS-B stated she expected the ULP to notify the nurse if a resident has medications in their apartment that are not listed on the MAR to ensure the resident has been assessed for appropriate use and storage of the medications. CNS-B stated she would reassess R1 and R2 for self-administration of medications. The licensee's Medication Self Administration policy dated March 1, 2024, indicated the following: 1. The resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. 2. The ability to self-administer medications will indicate: a. able to self-administer medications independently b. Able to self-administer medications with supervision, cueing and/or set-up c. Not able to self-administer medications safely 3. Residents who have been deemed appropriate to self-administer medications independently or with supervision/cuing or after set-up, shall have a physician order to do so. 4. Residents service plan will be updated with resident's ability to self-administer medication. 5. The Self-Administration screen will be re-evaluated annually and more frequently as clinically indicated. 6. Medications shall remain in the original container in which they were dispensed and be properly labeled in accordance with established policies governing the labeling of medications. 7. If a resident has a noted change in condition	01710		

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01710	Continued From page 34 this will be reported to the Director of Wellness or designee with re-screening for self-administration performed to ensure self-administration of medications is still safe. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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01730	Continued From page 35 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1 and 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) 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 June 8, 2026, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated resident medications	01730		

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01730	Continued From page 36 were stored mainly in a medication cart or medications that were set up were stored in a locked closet in the clinical nurse supervisor (CNS) office. Medications requiring refrigeration were stored in a secured refrigerator in the unlicensed personnel (ULP) office. R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration, diabetic management (including glucometer checks, insulin administration, coordination with provider as needed). On June 9, 2026, at 8:50 a.m., the surveyor observed ULP-C prepare R1's oral medications for administration. ULP-C stated R1 was independent with blood sugar checks and insulin administration, and the ULP would offer assistance but R1 usually declined. ULP-C administered R1's oral medications and asked her if she had checked her blood sugar yet. R1 stated her blood sugar was 185. ULP-C then asked R1 if she had administered her insulin already to which R1 stated "not yet". ULP-C asked R1 how much insulin she planned to self-administer. R1 stated "2.5 units". ULP-C left R1's room without supervising and verifying the amount of insulin R1 dialed and administered. ULP-C documented R1's blood sugar result and that 2.5 units of Humalog insulin were administered. R1's medication administration record (MAR) dated June 2026, included the following:	01730		

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01730	Continued From page 37 -Humalog Junior Kwikpen 100 units/ml; inject 3 units subcutaneously one time a day for diabetes. Supervised Self-administration. -Humalog Junior Kwikpen 100 units/ml; inject 4 units subcutaneously one time a day for diabetes. Supervised Self-administration. -Humalog Junior Kwikpen 100 units/ml; inject 5 units subcutaneously one time a day for diabetes. Supervised Self-administration. -Lantus Solostar insulin 100 units/ml; inject 10 units subcutaneously one time a day for diabetes. -Dextrose oral gel 40%; give 15 grams by mouth as needed for hypoglycemia (low blood sugar) unsupervised self-administration. Okay to keep at bedside for self-administration. -Glucose tablet 4 grams; chew one tablet by mouth as needed for low blood sugar. Please leave 3-5 tablets in resident room for her to utilize in the event of hypoglycemia. R1's Medication Self-Administration Safety Screen Assessment dated May 13, 2026, indicated the following: -List of all medications that are being considered for resident to self administer: polyethylene glycol powder, fluticasone propionate nasal spray, Humalog Junior Kwik Pen, and Insulin Degludec pen. -Review Summary: The resident is able to self-administer insulin after the staff verifies the insulin dosing. The resident may self-administer Miralax (polyethylene glycol) and Flonase (fluticasone propionate) unsupervised. R1's record contained an Individualized Medication Management Plan dated May 13, 2026, indicating the following: -Resident is able to self-administer insulin. Staff to verify insulin dosing. Resident may self-administer Miralax and Flonase unsupervised	01730		

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01730	Continued From page 38 and store at bedside. Staff administer/manage all other oral medication and keep stored in locked medication cart. -Resident is able to store opened insulin pens, Miralax and Flonase independently. Unopened insulin pens stored in locked refrigerator in HHA (home health aide) office. All other medications stored in locked medication cart. R1's medication management plan indicated staff would verify R1's insulin dosing prior to R1 self-administering the insulin; however, the ULP did not verify R1's insulin dosing prior to administration. R1's medication plan did not include self-administration and self-storage for Dextrose oral gel and glucose tablets for low blood sugar. R2 R2 was admitted on March 28, 2024, with diagnoses that included diabetes. On June 9, 2026, at 6:43 a.m., the surveyor observed ULP-C prepare R2's medications and insulin for administration. During the preparation of medications ULP-C stated R2 self-administered polyethylene glycol and then documented it as administered even though ULP-C did not administer the medication. ULP-C prepared the rest of R2's medications and brought them to R2's apartment. Prior to administering R2's insulin ULP-C asked R2 if he was going to administer the insulin or if he wanted her to administer it. R2 stated ULP-C could administer it. ULP-C administered R2's insulin as prescribed and administered R2's oral medications. At this time the surveyor observed one bottle of medication on R2's desk and one inhaler, one nasal spray and one bottle of medication on R2's bedside table. ULP-C	01730		

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01730	Continued From page 39 returned to the medication cart and documented administration of R2's medications and insulin. The surveyor inquired if R2 self-administered his insulin at times. ULP-C stated R2 used to self-administer his insulin most days but recently stated when his fingers felt numb he would have the ULP administer the insulin. ULP-C stated R2 self-administered the medications on his desk and bedside table. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's MAR dated June 2026, included the following: -polyethylene glycol powder; give 17 grams by mouth one time a day for constipation -Novolin insulin Flex pen; inject 45 units subcutaneously one time a day R2's Medication Self-Administration Safety Screen Assessment dated June 2, 2026, indicated the following: -List of all medications that are being considered for resident to self administer: clotrimazole external cream and Testosterone Transdermal gel. -Review Summary: Resident may self-administer topical creams without supervision. R2's record contained an Individualized Medication Management Plan dated May 20, 2026, indicating the following: -Resident is unable to store medications independently. Medications are kept in the locked medication cart R2's medication management plan did not	01730		

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01730	Continued From page 40 include R2's ability to self-administer medications and insulin, and the plan did not include self-storage of medications in R2's room. On June 10, 2026, at 12:15 p.m., CNS-B stated R1 and R2's medication management plans did not accurately reflect which medications and insulin were being self-administered by the resident and did not include self-storage of medication in R1 and R2's rooms. The licensee's Medication Management Individualized Plan policy dated August 18, 2024, indicated the facility will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medications supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management task that may be delegated to unlicensed personnel f. procedures for staff notifying an RN or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730		

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	30468	A. BUILDING: _____ B. WING _____	06/10/2026

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01730	Continued From page 41 reaction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R1) whose medication administration was delegated to unlicensed personnel (ULP). 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	01750		

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01750	Continued From page 42 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. On June 9, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration, diabetic management (including glucometer checks, insulin administration, coordination with provider as needed). R1's medication administration record (MAR) dated June 2026, included the following: -Dextrose oral gel 40%; give 15 grams by mouth as needed for hypoglycemia (low blood sugar) unsupervised self-administration. Okay to keep at bedside for self-administration. -Glucose tablet 4 grams; chew one tablet by mouth as needed for low blood sugar. Please leave 3-5 tablets in resident room for her to utilize in the event of hypoglycemia. R1's signed prescriber orders dated April 26, 2026, included the following medications: -Dextrose 40%; take 15 grams of dextrose by mouth as needed for low blood sugar. Okay to keep at bedside for self-administration -glucose 4 gram chewable tablets; chew one tablet as needed for low blood sugar. Please leave 3-5 tablets in resident room for her to utilize	01750		

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01750	Continued From page 43 in the event of hypoglycemia (low blood sugar) R1's record did not include instructions regarding what blood sugar result was considered a low blood sugar to indicate administering PRN (as needed) Dextrose gel or glucose tablets. In addition, there was no indication when to give the Dextrose gel verses the oral glucose when R1's blood sugar was low. On June 10, 2026, at 12:19 p.m., clinical nurse supervisor (CNS)-B stated R1's record did not include what blood sugar result was considered a low blood sugar or instructions regarding when to administer Dextrose gel verses glucose tablets. The licensee's Medication and Treatment Administration policy dated May 30, 2023, indicated when administration of medication or treatment/therapy is delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's record 3. communicated with the ULP about the individual needs of the residents No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 44	01760		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) reviewed with insulin administration. In addition, the licensee failed to ensure a resident's medication administration record (MAR) accurately reflected the correct medication prescribed and being administered. This resulted in an immediate order on June 9, 2026. In addition, the licensee failed to ensure medications were administered per prescriber's orders for two of two residents (R1 and R2) and failed to ensure medication administration was documented accurately for one of three residents (R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was	01760		

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01760	Continued From page 45 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: R1 was admitted on December 1, 2023, with diagnoses that included diabetes and retinal disorder. On June 9, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R1's oral medications for administration. ULP-C stated R1 was independent with blood sugar checks and insulin administration and the ULP would offer assistance but R1 usually declined. ULP-C administered R1's oral medications and asked her if she had checked her blood sugar yet. R1 stated her blood sugar was 185. ULP-C then asked R1 if she had administered her insulin already to which R1 stated "not yet". ULP-C asked R1 how much insulin she planned to self-administer. R1 stated "2.5 units". ULP-C left R1's room without supervising and verifying the amount of insulin R1 dialed and administered. ULP-C documented R1's blood sugar result and that 2.5 units of Humalog insulin were administered. The surveyor inquired about R1 administering a different dose of insulin than what was indicated in the medication administration record (MAR). ULP-C stated R1 administered her own insulin based off how she felt and what she ate. ULP-C stated R1 was blind and could not see the insulin units on the pen, so R1 would listen to the number of "clicks" the insulin pen made when she dialed each unit. ULP-C stated a few days ago R1 had left the facility for nine hours and forgot to bring her insulin with her. ULP-C stated when R1 returned her blood sugar was	01760		

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01760	Continued From page 46 over 300 and R1 just gave herself extra insulin to "correct things" since she didn't have her scheduled doses while she was out of the facility. R1's service plan dated December 15, 2025, indicated R1 received services to include medication administration and diabetic management (including glucometer checks, insulin administration, coordination with provider as needed). R1's signed prescriber orders dated April 26, 2026, included the following: - Humalog Junior Kwik Pen 100 units/milliliter (ml); Take three units with breakfast, four units with lunch, and five units with dinner; and - Insulin degludec 100 units/3 ml; inject 10 units under the skin at bedtime. R1's MAR dated June 2026, included the following orders and directions: - Humalog Junior Kwikpen 100 units/ml; inject three units subcutaneously one time a day at 9:30 a.m., for diabetes. Supervised Self-administration. Document ACTUAL dose resident self-administers. - On June 2, 5, 7, and 8, 2026, the ULP documented two units were administered; - On June 4 and 9, 2026, the ULP documented 2.5 units were administered; and - On June 6, 2026, the ULP documented five units were administered. -Humalog Junior Kwikpen 100 units/ml; inject four units subcutaneously one time a day at 11:00 a.m., for diabetes. Supervised Self-administration. Document ACTUAL dose resident self-administers. - On June 1, 2026, the ULP documented 6 units were administered; and	01760		

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01760	Continued From page 47 - On June 5, 2026, the ULP documented 8 units were administered. -Humalog Junior Kwikpen 100 units/ml; inject five units subcutaneously one time a day at 5:30 p.m., for diabetes. Supervised Self-administration. Document ACTUAL dose resident self-administers. - On June 1, 2026, the ULP documented 12 units were administered; and - On June 5, 2026, the ULP documented 6 units were administered. - Lantus Solostar insulin 100 units/ml; inject 10 units subcutaneously one time a day at 8:30 p.m., for diabetes. -The MAR indicated 10 units were administered June 1, 2026, through June 8, 2026. R1's June 2026 MAR did not contain instruction to ULP to notify the registered nurse (RN) if R1 wished to administer a different insulin dose than what was ordered nor did it contain any notes to indicate ULPs updated the RN. R1's progress notes authored by ULPs included the following: - On June 7, 2026, "14 units of Lantus administered plus 3 units of regular (Humalog) insulin d/t (due to) not having insulin while absent. Blood sugar: 337". - On June 8, 2026, 14 units of Lantus insulin were administered, not the prescribed 10 units. There were no follow up notes authored by the RN. R1's Individualized Medication Management Plan dated May 13, 2026, indicated the following: - partially able to self-administer medications; resident is able to self-administer insulin.	01760		

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01760	Continued From page 48 R1's Medication Self-Administration Safety Screen dated May 13, 2026, indicated the following: - resident can correctly state the correct dosage/quantity for each administration: completely capable; - resident can administer subcutaneous injections: completely capable; and - Review Summary: The resident is able to self-administer insulin after the staff verifies the insulin dosing. On June 9, 2026, at 9:03 a.m., the surveyor inquired with R1 about self-administering her insulin. R1 stated she was blind and "can't see my hand in front of my face" so she would have her husband who lived with her or the ULP dial the insulin to the dose she wanted. R1 stated she could self-inject the Humalog insulin but required assistance with injecting the Lantus insulin because the button was too hard to hold down. R1 stated she determined the dose of insulin based off how she felt and what she planned to eat. On June 9, 2026, at 10:01 a.m., clinical nurse supervisor (CNS)-B stated R1 had a blood sugar sensor that recorded R1's blood sugar on her phone. R1 would verbally report her blood sugar results to the ULP to document in R1's record. CNS-B stated R1's provider had tried to adjust R1's insulin doses based off of R1's blood sugar results however R1 refused to follow the prescriber orders and administered her Humalog insulin based off of how she felt and how much she ate. CNS-B stated R1 only adjusted the Humalog dose and not the Lantus dose. CNS-B stated R1 could dial her own insulin pen and would dial the pen to the dose she felt was	01760		

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01760	Continued From page 49 needed and then the ULP were supposed to verify that the dose R1 dialed was accurate to what R1 stated she was going to self-administer. CNS-B stated after the ULP verified the insulin dose they were to observe R1 self-administer the insulin to ensure she administered the full dose. The surveyor told CNS-B that R1 had reported that she was not able to self-inject her insulin at bedtime and required staff assistance. CNS-B stated R1 may have difficulty self-injecting the bedtime insulin because recently her insurance coverage switched and from insulin degludec to Lantus insulin and the insulin pens may be different. CNS-B stated she updated the MAR to reflect the change which is why the MAR indicated Lantus insulin was being administered every night at bedtime, however the prescriber orders indicate degludec insulin. CNS-B stated R1 did not have prescriber orders for sliding scale insulin (method of adjusting insulin doses based on current blood sugar levels) and R1's record lacked prescriber orders to include parameters of how many units of insulin R1 was able to adjust for administration. On June 9, 2026, at 11:50 a.m., CNS-B stated she had updated R1's provider on February 16, 2026, regarding R1 adjusting her insulin doses based on what R1 thought was needed. R1's provider responded via telephone encounter and documented "Keep Humalog doses the same, and request patient not take any additional Humalog beyond what is prescribed". The surveyor inquired if the licensee continued to update R1's provider regarding non-compliance with administering insulin as prescribed. CNS-B stated she had not specifically updated R1's provider that R1 continued to adjust her insulin doses as R1 felt necessary. CNS-B stated R1's recent provider progress note dated April 16,	01760		

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01760	Continued From page 50 2026, noted R1's non-compliance with her insulin. R1's Provider encounter dated April 16, 2026, indicated the following: "[R1's name] is a 79-year-old female with long-standing type 1 diabetes complicated by neuropathy and autonomic dysfunction who presents with dizziness. Over the past several weeks she has had worsening dizziness, lightheadedness, and imbalance, most noticeable when rising from sitting to standing and with prolonged standing or walking, especially when changing direction. She has had near-falls, including one fall onto her bed. She has no clear triggers or alleviating factors and fluid intake is good. She denies chest pain, palpitations, and shortness of breath. She has recurrent sharp bilateral frontal headaches several times per day. Headaches are brief and typically resolve before she can treat them. They occur at variable times including lying down, standing up, or walking without clear triggers. She denies unusual ear sensations and denies new visual phenomena with headaches beyond baseline visual impairment. For months she has had right upper pain localized to the bicep's region, absent at rest and provoked by reaching the arm back or turning the forearm, such as when removing a jacket. Pain improves with avoiding movement. Acetaminophen helps. She reports chronic right-sided weakness, remains able to feed and dress herself, and ambulates with walker. She has progressive short-term memory difficulty with forgetting names and misplacing items in the setting of worsening vision with inability to read and perceiving progressively less vision weekly, limiting use of written reminders. Blood sugars have been labile with frequent hyperglycemia; she feels unwell most when glucose is high and was high this morning, which she attributes to	01760		

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01760	Continued From page 51 less walking the prior day. She typically walks 2-3 miles per day when weather permits. She recently reduced long-acting insulin from 11 units to 10 units and varies Humalog based on glucose and activity. Discouraged her from giving additional insulin beyond what is prescribed, but she feels like she knows best how to manage her diabetes. This has led to hypoglycemia". On June 9, 2026, at 1:48 p.m., the surveyor inquired if the licensee had a signed prescriber order for the insulin change from degludec insulin to Lantus insulin. CNS-B stated R1 had not started using Lantus insulin yet. CNS-B stated she had updated the MAR to indicate the change to Lantus insulin due to insurance coverage, however R1 was using up her current supply of degludec insulin before changing to Lantus. CNS-B stated the staff were documenting the administration of degludec insulin in the MAR under Lantus insulin. CNS-B stated she would update R1's MAR to reflect degludec insulin was being administered until supply ran out and then change it to Lantus insulin once R1 switched. Humalog directions for use dated May 2025, indicated the following: - Take Humalog exactly as your healthcare provider tells you to. Do not change the type or amount of insulin you take unless your healthcare provider tells you to. - Humalog is a rapid-acting insulin. Inject Humalog within 15 minutes before or right after eating a meal. - Humalog may cause serious side effects that can lead to death, including: - low blood sugar. Signs and symptoms of low blood sugar may include dizziness or light-headedness, sweating, confusion, headache, blurred vision.	01760		

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01760	Continued From page 52 - rash over your whole body - trouble breathing - low potassium in your blood - heart failure - shortness of breath - swelling of your ankles or feet. The licensee's Medication Self-Administration policy dated March 1, 2024, indicated the following: 1. The resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. 2. The ability to self-administer medications will indicate: a. Able to self-administer medications independently b. Able to self-administer medications with supervision, cueing and/or set-up c. Not able to self-administer medications safely 3. Residents who have been deemed appropriate to self-administer medications independently or with supervision/cuing or after set-up, shall have a physician order to do so. 4. Residents service plan will be updated with resident's ability to self-administer medication. 5. The Self-Administration screen will be re-evaluated annually and more frequently as clinically indicated. 6. Medications shall remain in the original container in which they were dispensed and be properly labeled in accordance with established policies governing the labeling of medications. 7. If a resident has a noted change in condition this will be reported to the Director of Wellness or designee with re-screening for self-administration performed to ensure self-administration of medications is still safe.	01760		

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01760	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on June 9, 2026, to mitigate immediate risk to residents; however, the scope and level remains at G. PRESCRIBER ORDERS R1 R1's signed prescriber orders dated April 26, 2026, included the following medication: -calcium carbonate-vitamin D3 1,500 milligrams (mg)- 20 micrograms (mcg); take one tablet by mouth daily R1's MAR dated June 2026, did not include calcium carbonate-vitamin D3 On June 10, 2026, at 1:18 p.m., CNS-B stated R1's calcium carbonate-vitamin D3 was discontinued for non-use; however, could not locate the order to discontinue it. R2 R2 was admitted on March 28, 2024, with diagnoses that included diabetes. R2's service plan dated December 31, 2025, indicated R2 received services to include medication administration and diabetic management. R2's signed prescriber orders included the following: -albuterol 90 mcg inhaler; inhale two puffs every four hours as needed for wheezing or shortness of breath, order dated October 14, 2025 -mometasone (Nasonex) 50 mcg nasal spray;	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01760	Continued From page 54 administer two sprays into each nostril daily as needed (allergies), order dated May 29, 2026 R2's MAR dated June 2026, did not include albuterol inhaler or mometasone nasal spray. On June 10, 2026, at 12:24 p.m., CNS-B reviewed R2's signed prescriber orders and MAR and stated albuterol nebulizer and mometasone nasal spray should have been transcribed onto R2's MAR. CNS-B stated she was unsure why the orders were not implemented and would follow up with R2 and R2's provider to clarify if the medications are still needed or not, and update R2's record accordingly. The licensee's Medication and Treatment Orders policy dated September 1, 2025, indicated an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. DOCUMENTATION OF MEDICATION ADMINISTRATION R3 was admitted on December 1, 2023, with diagnoses that included dementia. On June 9, 2026, at 8:55 a.m., the surveyor observed ULP-C remove a pre-filled medication box from the medication cart. The medication box had a post-it note taped to the top of the box that indicated R2's Vitamin D3 (AM) had not yet arrived from the pharmacy and was not in the box. Mark as unavailable in the MAR. ULP-C counted three medications in the designated morning slot and stated one medication was missing. ULP-C stated R2's vitamin had run out a week ago and the licensee was waiting for a new	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01760	Continued From page 55 supply to be delivered. ULP-C documented that R2's Preservision vitamin was not administered due to being out of stock. ULP-C administered the three medications to R3. The surveyor inquired which vitamin was out of stock (Preservision or cholecalciferol). ULP-C reviewed R3's MAR and stated the Preservision was out of stock. R3's MAR dated June 2026, included the following medications: -cholecalciferol (Vitamin D3) 25 mcg; give one tablet by mouth one time a day -On June 2, 3, 4, 5, 8, and 9, 2026, the ULP documented the medication was administered as ordered -On June 6, and 7, 2026, the ULP documented the medication was not available from the pharmacy -Preservision oral tablet; give one capsule by mouth two times a day -On June 2, 6, and 7, 2026, the ULP documented the 9:30 a.m., dose was administered as ordered -On June 3, 4, 5, 8, and 9, 2026, the ULP documented the 9:30 a.m., dose was not available from the pharmacy -On June 2, 3, 4, 5, 6, 7, 8, and 9, 2026, the 5:25 p.m., dose of was administered as ordered On June 10, 2026, at 8:41 a.m., CNS-B stated she set up R3's medication once a week on Tuesdays. CNS-B stated R3 ran out of cholecalciferol and had put a note on his medication box to let the ULP know which medication was missing and to document that it was not available. CNS-B reviewed R3's MAR and stated the ULP did not document accurately as R3 had received Preservision as ordered and the only medication that should have been	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01760	Continued From page 56 documented as not available from Tuesday, June 2, 2026, through Tuesday, June 9, 2026, was cholecalciferol. No further information was provided.	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 June 8, 2026, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01770	Continued From page 57 R3 was admitted on December 1, 2023, with diagnoses that included dementia. On June 9, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3 from a pre-filled medication box. R3's service plan dated December 15, 2025, indicated R3 received services to include medication management services. R3's medication administration record (MAR) dated June 2026, included the following medications: -atorvastatin 80 milligrams (mg): give one tablet by mouth one time a day (cholesterol) -cholecalciferol 25 micrograms (mcg); give one tablet by mouth one time a day (supplement) -lisinopril-hydrochlorothiazide 10-12.5 mg; give one tablet by mouth one time a day (blood pressure) -rivastigmine transdermal patch 9.5 mg/24 hours; apply one patch transdermally one time a day (dementia) -tamsulosin 0.4 mg; give one capsule by mouth one time a day (prostate) -memantine 10 mg; give one tablet by mouth two times a day (dementia) -Preservision capsule; give one capsule by mouth two times a day (supplement) R3's progress notes dated March 23, 2026, included "one week of medications set-up in weekly med box for staff administration". R3's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01770	Continued From page 58 administered, and route of administration. On June 10, 2026, at 12:21 p.m., CNS-B stated she set up R3's medications once a week. CNS-B stated sometimes the medication setup would be documented in a progress note; however, R3's record lacked any progress notes for medication setup after March 23, 2026. CNS-B further stated she did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in the resident record. The licensee's Medication Management- Dosage Box Setup policy dated September 1, 2025, indicated the following: 1. A licensed nurse will assure the medication orders are transcribed onto the MAR. This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 2. The licensed nurse transcribes the medications order onto the MAR. For medications included in the dosage box, the day and time of administration will be noted on the MAR. 3. Medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and: a. Medication name b. Quantity of dose c. Times to be administered d. Route of administration e. Visual description of medication	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

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01770	Continued From page 59 f. Drug classification and special precautions 4. The licensed nurse sets up medication weekly into the dosage boxes. 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. 6. The licensed nurse will review the dosage boxes on a weekly basis to assure that all the previous week's medications were administered, and documentation is then made on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 60 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on March 31, 2022, and discharged on March 9, 2026. R4's medication administration record (MAR) dated December 2025, included the following medications: -calcium carbonate-vitamin D 600-10 milligrams (mg)-10 micrograms (mcg); give one tablet by mouth one time a day (supplement) -cholecalciferol 125 mcg; give one capsule by mouth one time a day on Mondays (supplement) -cyanocobalamin 1,000 mcg; give one tablet by mouth one time a day (supplement) -furosemide 20 mg; give one tablet by mouth one time a day (diuretic) -losartan 100 mg; give one tablet by mouth one time a day (blood pressure) -mirabegron 25 mg; give one tablet by mouth one time a day (overactive bladder) -mirtazapine 15 mg; give one tablet by mouth one time a day (anxiety)	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

(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
01910	Continued From page 61 -warfarin 1 mg; give one tablet by mouth every Tuesday, Friday and Sunday (blood thinner) -warfarin 1 mg; give one and one-half tablet by mouth every Monday, Wednesday, Thursday and Saturday (blood thinner) -carvedilol 6.25 mg; give one tablet by mouth two times a day (blood pressure) -Tylenol 500 mg; give two tablets by mouth three times a day (pain) R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On June 10, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated R4's medications were sent with family. CNS-B stated she had not documented the disposition of medications. The licensee's Medication Disposal policy dated September 2, 2025, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

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02310	Continued From page 62	02310		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On June 8, 2026, during the engineer's survey visit, the engineer observed R5's room with one unsecured oxygen cylinder on the floor. On June 10, 2026, at 12:26 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the unsecured oxygen cylinders in R5's room and would remind R5 to store his oxygen in secured holder. The licensee's Oxygen policy dated September 1,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA AT PINE HAVEN	220 3RD STREET NW PINE ISLAND, MN 55963

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02310	Continued From page 63 2025, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

EVERGREEN PLACE
220 3RD STREET NW
Pine Island, MN 55963
Goodhue County
Parcel:

Phone:

License Info

License: HFID 30468

Risk:
License:
Expires on:
CFPM: Sarah Rose Wangen
CFPM #: 60529; Exp: 09/10/2028

Inspection Info

Report Number: F8044261172
Inspection Type: Full - Single
Date: 6/8/2026 Time: 10:36:16 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD inspection conducted with Kassie Marking. Report reviewed on site with Sarah Wangen.

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

I acknowledge receipt of the Rochester District Office inspection report number F8044261172 from 6/8/2026

Sarah Wangen

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

EVERGREEN PLACE
Pine Island
County/Group: Goodhue County

Inspection Info

Report Number: F8044261172
Inspection Type: Full
Date: 6/8/2026
Time: 10:36:16 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40.1 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler at 43.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed potatoes**; Temperature Process:** Hot-Holding
Location: Cambro at 140.5 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

EVERGREEN PLACE
Pine Island
County/Group: Goodhue County

Inspection Info

Report Number: F8044261172
Inspection Type: Full
Date: 6/8/2026
Time: 10:36:16 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30468016	**Date:** 6/8/2026
Facility Name: Vista at Pine Haven	
Facility Address: 220 3rd St NW, Pine Island, MN 55963	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments:

   There were holes behind two of the sprinkler heads in the facility. Two sprinkler heads in the facility had portions of the wall cut away directly behind the heads according to facility staff and the holes had not yet been filled, although facility staff stated that repairs are planned. The holes should be filled, and the walls should be maintained around sprinkler heads to ensure proper and timely operation of the sprinkler system.

   The sprinkler system did not have an accurate hydraulic information placard attached to the system riser displaying required information. A hydraulic placard was attached to the system but did not have legible information and appeared to have been wiped away. Placards should be supplied and maintained with all relevant data and information on the system.

   A large bird nest was present on top of the fire alarm box above the fire department connection on the exterior of the building, which obstructed the alarm. Fire alarm equipment should be maintained free of obstruction.

   The fire rating placards on fire doors around the facility were painted over and difficult to read. Fire rated doors should have the appropriate rating placards displayed and unobstructed.

The fire department connection was overdue for an inspection and did not have current inspection records. Facility staff confirmed that the required inspection for the fire department connection had been conducted. Facility staff did not have current paperwork for the fire department connection and inspection records indicated that the system needed updated inspection. During the survey facility staff contacted a company to schedule the inspection.

3. Access doors for automatic sprinkler system riser rooms and fire pump rooms shall be labeled with an approved sign. The lettering shall be in contrasting color to the background. Letters shall have a minimum height of 2 inches (51 mm) with a minimum stroke of 3/8 inch (10 mm). [Minn. Stat. 144G.45 subd. 2; MSFC 901.4.6.2]

   Comments: There was no signage on the sprinkler riser room indicating its use. Sprinkler rooms should be properly identified.

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

   Comments: The fire door to the laundry room was propped open with a door wedge that prevented the door from properly closing and latching. The door wedge should be removed, and fire doors should be maintained free of obstruction.

☒ **TAG IDENTIFICATION: 0790**

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

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments:

   The fire extinguisher installed in the elevator maintenance room did not have current annual inspection tags. The tag on the extinguisher indicated that the extinguisher had last been serviced in October 2024. Extinguishers should receive annual inspections by a licensed contractor and monthly visual inspections by facility staff.

   An older model extinguisher was installed in resident room 110 without any record of annual servicing or monthly inspections. The extinguisher should be removed or kept current with required servicing and maintenance.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee failed to provide a copy of the FSEP that was readily available within the facility. The only copy of the FSEP was stored in the administrator's office in the skilled nursing facility which is attached to the assisted living facility. A copy of the FSEP should be stored in the assisted living facility and should be readily accessible at all times.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to include a copy of maps or other plans that indicated the location and number of resident rooms in the FSEP. Documentation of the number and location of resident rooms should be maintained in the FSEP.

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

   Comments: The licensee failed to include appropriate staff actions for evacuation in the FSEP. The staff actions included in FSEP documentation were outdated and inaccurate. The actions included were not relevant to the facility site. Staff actions should be updated to include detailed and accurate actions during evacuation. Facility staff stated that documents in the FSEP were outdated and were from the previous ownership of the facility and that new plans are being created.

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

   Comments: The licensee failed to include fire protection procedures necessary for residents in the FSEP. Specific resident procedures for evacuation should be provided and maintained.