Electronically Delivered

August 5, 2026

Licensee
Elmhurst Commons Apartments
400 3rd Street Southwest
Braham, MN 55006

RE: Project Number(s) SL30591016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30591	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST COMMONS APARTMENTS	400 3RD STREET SW BRAHAM, MN 55006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30591016-0 On July 20, 2026, through July 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 32 resident(s); 31 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of two employees unlicensed personnel (ULP)-E. 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	0 660		

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0 660	Continued From page 4 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The facility TB risk assessment was completed June 30, 2026, and indicated the facility was at a low risk for TB transmission. On July 20, 2026, at 8:40 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E was hired September 28, 2023, to provide direct care services to residents. ULP-E's employee record lacked documentation ULP-E completed a two-step TST or other blood test completed by the licensee upon hire. ULP-E's record included TB Testing Documentation - one step Mantoux dated September 14, 2023, and read on September 17, 2023, with negative result. ULP-E's record lacked the second step Mantoux with reading. On July 22, 2026, licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-E is missing the second step of the Mantoux and must not have went back to get the second step completed, ULP-E is scheduled to get another TB test completed today. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) dated June 5, 2026, indicated baseline TB screening includes: - assessing current symptoms of active TB disease;	0 660		

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0 660	Continued From page 5 - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated Staff whose essential job functions require work within the same airspace of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline screening will be completed, but serial screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: - new staff will be screened for active signs of TB using the Baseline TB Screening Tool for healthcare workers (HCW)'s; and - new staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCW's. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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;	0 680		

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0 680	Continued From page 6 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. Additionally, the licensee failed to post the EPP prominently. This had the potential to affect all residents receiving services under the provisional assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 12:05 p.m., the surveyor did	0 680		

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0 680	Continued From page 7 not observe the licensee's EPP posted prominently. The licensee's undated EPP lacked the following required content: -maintain and annual EPP updates; -EPP resident population; -policies and procedures for tracking of staff and residents; -policies and procedures for volunteers; -names and contact information; -emergency officials contact information; On July 20, 2026, at 12:05 p.m., housing manager (HM)-C verified the EPP was missing maintenance of the EPP, resident population, policy for tracing staff and residents, policy for volunteers, names and contact information, and emergency officials contact information. HM-C stated the EPP is stored in a locked office and is not posted prominently. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The licensee's Missing Person policy dated August 1, 2021, indicated licensee will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications,	0 680		

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0 680	Continued From page 8 methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical	0 775		

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0 775	Continued From page 9 Environment Inspection Report (PEIR) dated July 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 July 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 790		

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0 790	Continued From page 11 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 22, 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=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 12 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements	0 810		

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0 810	Continued From page 13 of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 14 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 15 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: R1 was admitted to the licensee on December 2, 2015, with diagnoses which included traumatic brain injury, epilepsy, spinal cord injury, paraplegia, legally blind and hypertension. R1's progress notes dated June 22, 2026, indicated resident was sent to the emergency room over the weekend. It was determined that he had pneumonia, he returned with an order for Ceftin. He does not require a change to services at this time. R1's record lacked a written notice provided to R1 which included: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 16 information for the agency to which the resident may submit an appeal. - this notice must be delivered as soon as practicable to: - the resident, legal representative, and designate representative; - the resident's case manager; and - notify Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On July 21, 2026, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated R1 was in the hospital from June 18, 2026, through June 22, 2026. On July 21, 2026, at 2:51 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated an emergency relocation notification was not sent to the resident as soon as practicable and the Ombudsman was not sent a notification that R1 was still in the hospital on the fourth day of admission as required. LALD/LPN-A stated they thought the notification was not required until the fourth day of admission and so they have not been completing the emergency relocation notification for any residents, their representatives, or the case manager as soon as practicable and before the fourth day mark. The licensee's emergency relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, licensee will provide a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care;	01060		

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01060	Continued From page 17 - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. The facility will provide contact information for the agency to which the resident may submit an appeal. The notice required will be delivered as soon as practicable to: - the resident, legal representative, and designated representative; - for residents who receive home and community-based waiver services, the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380		

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01380	Continued From page 18 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required training and competency was completed for one of two employees (unlicensed personnel (ULP)-H). 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-H ULP-H was hired on May 21, 2025, to provide direct care services to residents. ULP-H's employee record lacked documentation of the following required training to be completed by ULP: - understanding appropriate boundaries between staff and residents and the resident's family. On July 22, 2026, at 12:30 p.m., licensed assisted living facility/licensed practical nurse (LALD/LPN)-A stated she agrees ULP-H is missing the professional boundaries training and	01380		

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01380	Continued From page 19 she is not sure why because it should auto populate for new hires. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency for all ULP's will include: - understanding appropriate boundaries between staff and residents and the resident's family. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 20 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility	01470		

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01470	Continued From page 21 licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-E and ULP-H). 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: ULP-E On July 20, 2026, at 8:40 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E was hired September 28, 2023, to provide direct care services to residents. ULP-E's employee record lacked the following required orientation content: - review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-H ULP-H was hired on May 21, 2025, to provide direct care services to residents. ULP-H's employee record lacked the following required orientation content: - review of types of Assisted Living services the employee will provide and provider's scope of license.	01470		

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01470	Continued From page 22 On July 22, 2026, at 1:15 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all staff would be missing evidence of Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) review at orientation, they go over it verbally but do not have any documentation of this. The licensee's Orientation of Staff and Supervisors & Content policy dated July 18, 2025, indicated all licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The materials and/or type of training (i.e. video, lecture, reading, etc.} will be documented for compliance. The orientation must contain the following topic: - the facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500		

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01500	Continued From page 23 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500		

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01500	Continued From page 24 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-E and ULP-H). 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 the residents). The findings include: ULP-E On July 20, 2026, at 8:40 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E was hired September 28, 2023, to provide direct care services to residents. ULP-H ULP-H was hired on May 21, 2025, to provide direct care services to residents. ULP-E and ULP-H's employee records lacked evidence annual training had been completed as	01500		

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01500	Continued From page 25 required in the following areas: - review of provider's policies and procedures. On July 22, 2026, at 12:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the staff review some polices online through the electronic charting system but they currently do not have evidence of any staff completing an annual review of all the licensee's policies and procedures. The licensee's Annual Required Staff Training policy dated July 18, 2025, indicated the following training elements must be included every 12 months for all staff who performs direct care services: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date.	01530		

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01530	Continued From page 26 Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for one of two employees (unlicensed personnel (ULP)-H).	01530		

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	30591	A. BUILDING: _____ B. WING _____	07/22/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 27 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-H was hired on May 21, 2025, to provide direct care services to residents. ULP-H's employee record indicated ULP-H completed 5.25 hours of initial dementia training, thus did not contain documentation ULP-H completed the required initial eight hours of dementia training, within 160 working hours of ULP-H's employment start date under the assisted living license. On July 22, 2026, at 12:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A agreed ULP-H was missing the full 8 hours of initial dementia training and is unsure why, because all the required classes should auto populate. The licensee's Dementia, Mental Illness & De-escalation policy dated July 18, 2025, indicated direct care staff, initial training (within 160 working hours of employment state date): - 8 hours of dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01530		

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01530	Continued From page 28 (21) days	01530		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not 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 staff document the reason why medication administration was not completed as prescribed, for one of two residents (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 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:	01760		

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01760	Continued From page 29 On July 21, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1 was admitted to the licensee on December 2, 2015, with diagnoses which included traumatic brain injury, epilepsy, spinal cord injury, paraplegia, legally blind and hypertension. R1's Service Plan, dated December 8, 2025, indicated R1 received services including bathing, compression stockings, escorts, dressing, housekeeping, laundry, behavior management, medication assistance, and vital sign monitoring. R1's signed provider orders dated December 6, 2026, indicated orders including but not limited to the following: -Bentyl 10 milligrams (mg) by mouth four times a day for bowel irritations; and - simethicone 125mg by mouth three times a day for gas relief. R1's medication administration record (MAR) dated June 1, 2026, to June 30, 2026, indicated R1 was not administered the following medications in June 2026, contrary to the provider orders above: - Bentyl 10mg, not administered on June 10, 11, and 14, 2026 at 12:30 p.m.; and - simethicone 125mg, not administered on June 11 and 14, 2026 at 12:30 p.m. R1's MAR dated July 1, 2026, to July 20, 2026, indicated R1 was not administered the following medications in July 2026, contrary to the provider orders above: - Bentyl 10mg, not administered on July 2 and 6, 2026 at 12:30 p.m.; and	01760		

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01760	Continued From page 30 - simethicone 125mg, not administered on July 2 and 6, 2026 at 12:30 p.m. On July 21, 2026, at 2:40 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she agreed R1's MAR's for June and July at 12:30 p.m., are missing some of the required initials indicating a medication was administered or not but she thinks the medications were administered the staff just forgot to sign the MAR. The licensee's Medication & Treatment Record-Documentation & Refusal policy dated August 1, 2021, indicated the following must be documented in the residence medication and/or treatment/therapy records after providing medication assistance or administration: - the date; - the time; - the quantity of dosage; - the method of administration of all prescribed legend and over the counter medications and or treatments/therapy; and - signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy. If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. Documentation of medication/treatment/therapy reminders, medication/treatment/ therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed.	01760		

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01760	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include 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 On July 21, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 and assistance with morning cares which included application of compression stockings. R1 was admitted to the licensee on December 2, 2015, with diagnoses which included traumatic brain injury, epilepsy, spinal cord injury, paraplegia, legally blind and hypertension. R1's Service Plan, dated December 8, 2025, indicated R1 received services including bathing, compression stockings, escorts, dressing, housekeeping, laundry, behavior management, medication assistance, and vital sign monitoring. R1's signed provider orders dated December 6, 2026, indicated the following treatment: - compression stockings daily, put on	01940		

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01940	Continued From page 33 ThromboEmbolic Deterrent (TED's) at this time. Put Velcro wrap on left leg. Pull to 30-40 mm compression. R2 R2 was admitted to the licensee on April 19, 2011 and started to received assisted living services on August 1, 2021, with diagnoses which included epilepsy, atrial fibrillation, hypertension, and morbid obesity. R2's Service Plan, dated December 8, 2025, indicated R2 received services to include assistance with bathing, blood glucose monitoring, continuous positive airway pressure (CPAP) assistance, housekeeping, laundry, behavior management, medication assistance, and vital sign monitoring. R2's signed physician order dated May 3, 2026, indicated the following treatments: - blood glucose monitoring daily, check residents blood sugar level; and -CPAP task, home health aide (HHA) will fill CPAP machine with bottled water, wipe machine down as needed and turn machine on/off as needed. R1 and R2's individualized treatment plans both lacked the following required information: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent complications or adverse reactions.	01940		

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01940	Continued From page 34 On July 21, 1016, at 2:40 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she agreed the treatment plan forR1's compression stockings was missing when to notify a nurse, specific instructions and what the staff should be monitoring for to prevent complications or adverse reactions to the treatment and this will need to be added to R1's treatment plan. On July 22, 2026, at 9:20 a.m., LALD/LPN-A stated she agrees all the residents' treatment plans are missing specific instructions, when to notify the nurse and what the staff should monitor for to prevent complications and they will need to update all the treatment plans to include these requirements. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; - any resident specific requirements relating to documentation of treatment and therapy received; - verification that all treatment and therapy was administered as prescribed; and	01940		

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01940	Continued From page 35 - monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, unlicensed personnel (ULP) were trained in the proper methods to perform treatment and the ULP had demonstrated	01950		

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01950	Continued From page 36 competency back to the registered nurse (RN) for two of two unlicensed personnel (ULP-E and ULP-H). 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 the residents). The findings include: During the entrance conference on July 20, 2026, at 10:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A and stated they provided treatment management services to include compression stockings and orthotic braces. ULP-E On July 20, 2026, at 8:40 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E was hired September 28, 2023, to provide direct care services to residents. ULP-H ULP-H was hired on May 21, 2025, to provide direct care services to residents. ULP-E and ULP-H's employee records lacked evidence that ULP-E and ULP-H had demonstrated competency back to the RN for compression stockings and orthotic braces.	01950		

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01950	Continued From page 37 On July 22, 2026, at 12:30 p.m., LALD/LPN-A stated she agrees all staff would be missing the competency evaluation for orthotic braces because they do not have one and will need to create it and both staff are missing the competency evaluation for compression stockings but she is not sure why the evaluation is missing because it has always been a part of the competency evaluation packets. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated Additional nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by an RN include: - Thrombo-Embolus Deterrent (Ted) compression stockings; - leg braces; and - ankle-foot orthosis (AFO) brace. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02320		

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02320	Continued From page 38 review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to hospital-style bed rails for 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) 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: On July 21, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 and assistance with morning cares which included application of compression stockings. R1's bed was a hospital bed with bilateral upper bed rails attached. R1 was admitted to the licensee on December 2, 2015, with diagnoses which included traumatic brain injury, epilepsy, spinal cord injury, paraplegia, legally blind and hypertension. R1's Service Plan, dated December 8, 2025, indicated R1 received services including bathing, compression stockings, escorts, dressing, housekeeping, laundry, behavior management, medication assistance, and vital sign monitoring. R1's Bed Safety assessment dated June 24, 2026, included: - an assessment; and - the risk vs. benefits were discussed and documented with the resident.	02320		

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02320	Continued From page 39 R1's Bed Safety assessment lacked: - all required measurements were completed and documented; and - the rails were Food and Drug Administration (FDA) compliant. On July 21, 2026, at 2:55 p.m., registered nurse (RN)-G stated she is responsible for the assessments and missed putting the specific measurements and is the bed rail is FDA compliant but will add these missing items today, this would be the case for all residents with bed rails and she will need to complete an audit to make sure all missing items are in the assessments. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) last updated April 17, 2026, indicated, in summary, what is the best way for my survey to pass with flying colors related to the use of bedrails? - an assessment was completed; - measurements were completed and documented; - the rails were FDA compliant; and - the risk vs. benefits were discussed and documented with the resident/responsible party. The licensee's Side Rails policy dated August 1, 2021, indicated When licensee is aware a home care resident is utilizing side rails on a bed, Licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verified that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and	02320		

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02320	Continued From page 40 the wrist regarding the use of the side rail. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02320		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ELMHURST COMMONS APARTMENTS
400 3RD STREET SW
Braham, MN 55006
Isanti County
Parcel:

Phone:
angel.kahler@vqpm.com

License Info

License: HFID 30591

Risk:
License:
Expires on:
CFPM: ANGEL NICOLE KAHLER
CFPM #: 63307; Exp: 12/1/2028

Inspection Info

Report Number: F1029261233
Inspection Type: Full - Single
Date: 7/20/2026 Time: 11:18:44 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

New Order: 3-200B Food Characteristics:Receiving: temperature, condition
3-202.15 *Priority Level: Priority 2 CFP#: 13*
MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.
COMMENT: CAN WITH DENTED SEAM. PIC INSTRUCTED TO REMOVE FROM SERVICE AND TO ENSURE THAT FUTRE CANS WITH DENTED SEAMS, AND CANS WITH ACIDIC CONTENT WITH LARGE DENTS ARE REMOVED FROM SERVICE.
Comply By: 7/20/2026 Originally Issued On: 7/20/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: POPCORN CEILING IN LOWER LEVEL FOOD/BEVERAGE ROOM WITH LIQUID DAMAGE IN UPPER EDGE. PIC INSTRUCTED TO ELIMINATE UNDERLYING SOURCE OF LIQUID DAMAGE; MOVE ITEMS AWAY FROM SOURCE OF CONTAMINATION UNTIL FIXED; AND TO ENSURE CEILINGS AND WALLS ARE SMOOTH, NON-ABSORBENT, AND EASILY CLEANABLE.
Comply By: 2/2/2027 Originally Issued On: 7/20/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS ITEMS IN LOWER AREAS OF 2-DOOR UPRIGHT IN DANGER ZONE. AIR FLOW POSSIBLY RESTRICTED TO UPPER AREA DUE TO FOOD STACKING. PIC INSTRUCTED TO DISCARD ALL TEMPERATURE ABUSED TCS FOODS; ADJUST, REPAIR, OR REPLACE COOLER; AND TO VERIFY SAFE COLD HOLDING (33-41F) THROUGHOUT COOLER PRIOR TO PLACING MORE TCS ITEMS WITHIN.
Comply By: 7/20/2026 Originally Issued On: 7/20/2026

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: OPENED PACKAGE OF SLICED HAM WITH NO OPEN DATE MARK AND MANUFACTURER'S USE BY DATE OF 6/12/26. PIC INSTRUCTED TO DISCARD, DATE MARK FUTURE OPENED REQUIRED ITEMS, DISCARD AFTER 7 DAYS, AND TO ENSURE THE IN HOUSE DATE MARK DOES NOT EXCEED THE MANUFACTURER'S USE BY DATE.
Comply By: 7/20/2026 Originally Issued On: 7/20/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: 2-DOOR UPRIGHT NOT MAINTAINING AT 41F OR LESS. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE TO ENSURE SAFE COLD HOLDING TEMPERATURES.
Comply By: 7/22/2026 Originally Issued On: 7/20/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD SURVEY OF ALF.

HRD NURSE EVALUATOR: SARABETH REMKER, BSN, RN

ESTABLISHMENT COMMERCIAL IN NATURE. FOODBORNE ILLNESS RISK FACTORS REVIEWED WITH PIC.

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 Metro District Office inspection report number F1029261233 from 7/20/2026

Trevor McCliment

ANGEL KAHLER
PERSON IN CHARGE

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

ELMHURST COMMONS APARTMENTS
Braham
County/Group: Isanti County

Inspection Info

Report Number: F1029261233
Inspection Type: Full
Date: 7/20/2026
Time: 11:18:44 AM

New Record: Product/Item/Unit: CHICKEN SOUP**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: SLICED ROAST BEEF**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 46 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: CHILI**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: HARD BOILED EGGS**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: DELI SALAD**; Temperature Process:** Cold-Holding
Location: LOWER ROOM UPRIGHT COOLER at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MASHED POTATOES**; Temperature Process:** Hot-Holding
Location: Steam Table at 166 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

ELMHURST COMMONS APARTMENTS
Braham
County/Group: Isanti County

Inspection Info

Report Number: F1029261233
Inspection Type: Full
Date: 7/20/2026
Time: 11:18:44 AM

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

Sanitizing Chemical: Product: QAC**; Sanitizing Process:** Dispenser
Location: Equal To 300 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30591016-0	**Date:** July 22, 2026
Facility Name: Elmhurst Commons Apartments	
Facility Address: 400 3rd Street SW, Braham, MN 55006	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Fire doors shall be maintained to be self-closing and latch as designed. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments:
   - The door closer had been disconnected from the labeled one hour fire door for the north storage room.
   - The labeled one hour fire doors for the trash rooms on both floor levels did not positively latch.
   Fire doors shall be maintained to close and latch automatically after every use, preventing the spread of smoke and fire in the event of an emergency.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall not be affixed to structures. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An orange extension cord attached to the wall was used to supply power to the medication refrigerator in the mechanical/storage room.

4. Single- and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: During the building tour, housing manager (HM)-C stated they did not know the age of the smoke alarms installed in resident unit 105. HM-C-removed the smoke alarm from the bracket in the

hallway. The back of the smoke alarm listed BRK Electronics model 4120B. Record review indicated this smoke alarm model was discontinued in 2004 and was more than ten years from date of manufacture.

5. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Gas fired mechanical equipment was installed in the building. A carbon monoxide detection system was not installed in the building and carbon monoxide alarms were not installed within ten feet of all resident bedrooms. Housing manager (HM)-C stated there were battery operated carbon monoxide alarms installed in the mechanical rooms and as smoke alarms were replaced in resident units, combination smoke and carbon monoxide alarms were being installed.

6. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   Comments: In the housekeeping storage room, the sprinkler head was obstructed by the storage of boxes less than 18 inches below the deflector. Improper storage under a sprinkler head deflector would interfere with the spray pattern of water in the event of a fire.

7. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: The cover was missing from one electrical wall outlet in occupied resident room 112. Electrical outlet covers shall be installed to prevent accidental contact with live electrical components.

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments: In occupied resident unit 112, when housing manager (HM)-C tested the smoke alarm outside the bedroom, the smoke alarm inside the bedroom was not actuated. The smoke alarms in this dwelling unit were not interconnected. This was corrected while the surveyor was onsite.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments:
   - The tag attached to the fire extinguisher in the maintenance room was dated 2019, indicating annual maintenance had not been performed by certified service personnel in the last year.
   - The fire extinguishers installed in the mechanical and elevators rooms were lacking monthly inspections. Fire extinguisher inspections must be completed every month and documented to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.
   - There was a fire extinguisher without a tag in a storage closet. Housing manager (HM)-C stated this was a spare and would be removed.

☒ **TAG IDENTIFICATION: 0810**

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

1. 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 door number for resident room 211 was covered by decorations. Resident room numbers need to be visible to provide efficient communication for exiting in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The provided fire safety and evacuation plan (FSEP) failed to include evacuation procedures for the individualized unique needs of residents. House manager (HM)-C stated resident emergency evacuation procedures were maintained in a binder stored in the locked home health aid office. These procedures would not be easily accessible to all staff or emergency responders during a fire or similar emergency.

3. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed in the past year, from housing manager (HM)-C. Fire drill reports were provided indicating drills were completed in July, August, and October of 2025, and in January and April of 2026. Additionally, one PM shift and one overnight shift drill were completed in the last year. Evacuation drills were not completed at the required frequency.