



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 15, 2026

Licensee
River Oaks At Watertown
409 Jefferson Avenue Southwest
Watertown, MN 55388

RE: Project Number(s) SL34299016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388			
(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: SL34299016-0 On May 11, 2026, through May 13, 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 46 residents; all of whom were 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.		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of three employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on March 11, 2024, to perform direct care services to residents. On May 12, 2026, from 9:33 a.m., through 10:04 a.m., during continuous observation surveyor observed ULP-G provide morning cares to R4.	0 510			

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0 510	Continued From page 2 ULP-G washed hands and donned gloves, and administered R4's inhaler and blood sugar via a blood glucose sensor. ULP-G picked up garbage off of R4's room and threw it away in the waste basket, then removed soiled gloves and without performing hand hygiene, ULP-G donned new gloves and applied a medicated cream to R4's knees. ULP-G removed gloves and without performing hand hygiene, ULP-G donned new gloves and assisted R4 with peri care and removed gloves and without performing hand hygiene, ULP-G donned new gloves and assisted R4 onto a bed pan for R4 to have a bowel movement, ULP-G then assisted R4 with peri care again and without performing hand hygiene, ULP-G donned new gloves and applied powder to R4 and without performing hand hygiene, ULP-G removed gloves and assisted R4 with preparing a bowl of cereal, and then administered R4's oral medications and injectable medication, and then left R4's room and went and washed hands. On May 12, 2026, at 10:04 ULP-G stated, "Typically we wash our hands before we go in to do cares and then again after all cares are completed, and I just change gloves whenever I feel they are soiled." On May 13, 2026, at 7:48 a.m., clinical nurse supervisor (CNS)-D stated, "Staff should be washing hands anytime they are visibly soiled, I do train they should wash at beginning and end of shift and if they put on gloves they should be going right into the room and foam in and foam out between residents and med passes." The licensee's Hand Hygiene policy dated May 31, 2023, indicated, "Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes	0 510			

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0 510	Continued From page 3 place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gowns e. Before eating and after using a restroom" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced	0 550			

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0 550	Continued From page 4 by: Based on observation and interview, the licensee failed to post the required information related to its grievance procedure, with all required content. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances. Upon entrance into the facility on May 11, 2026, at 11:30 a.m., the surveyor conducted a brief tour of the main entryway, common areas, hallway near the nursing and medication areas and hallway leading to the dining area and found no information of display informing about the licensee's grievance procedure near the main entrance or adjacent common areas. On May 13, 2026, at 12:30 p.m., licensed assisted living director (LALD)-C acknowledged they did not have the grievance procedure posted anywhere else and stated, "Staff have access to it, they typically have to request them from staff, but staff can get them for them, typically it does	0 550			

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0 550	Continued From page 5 go through staff but I have gotten hand written notes." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650			

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0 650	Continued From page 6 records included all required content for two of two employees (unlicensed personnel (ULP)-B and ULP-E) with employee records reviewed. 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-B ULP-B was hired on January 22, 2026, to perform direct care services to residents. On May 12, 2026, at 6:30 a.m. surveyor observed ULP-B give end of shift report to other staff. ULP-B employee record lacked a job description. ULP-E ULP-E was hired on November 5, 2025, to perform direct care services to residents. On May 12, 2026, at 9:34 a.m. surveyor observed ULP-E assisting R4 with toileting. ULP-E employee record lacked a job description. On May 12, 2026, at 12:56 p.m., licensed assisted living director (LALD)-C stated, "As far as job descriptions go, it looks like that may have been an oversight on our part, I am not seeing them in staff files."	0 650			

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0 650	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 8 content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan dated on February 21, 2025, and again on May 11, 2026, after the initiation of survey failed to include the required content: -documentation of being reviewed annually; -documentation of the missing resident plan that must be reviewed quarterly; -policy and procedures (P/P) to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -p/p to identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; and -p/p to identify which staff would assume specific roles in another's absence through succession planning and delegation of authority. On May 13, 2026, at 10:15 a.m., director of operations (DO)-H acknowledged the EP plan was not all completed and there was missing items, and stated, "We talked about patient population yesterday with engineering and no we don't have something like that."	0 680			

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0 680	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for one of one residents. 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 May 12, 2025, at 7:13 a.m., the surveyor observed the number four medication cart located	0 700			

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0 700	Continued From page 10 in the common activities room. Located on top of one medication cart an empty medication bottle for R7 that included R7's name, prescription and instructions for use. On May 13, 2026, at 7:34 a.m., clinical nurse supervisor (CNS)-D stated, "We always remind the staff that any time they leave the cart, they need to be locked, and you shouldn't leave any medications on the cart that can be seen by others, and you should never leave resident patient information open for others to see." The licensee's Security of Resident Records policy, dated June 20, 2023, indicated, "Resident records will be kept secure and protected against loss, tampering or unauthorized disclosure." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730			

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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
0 730	Continued From page 11 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 ensure the resident record included a discharge summary with the required content for two of two discharged residents (R1 and R5).	0 730			

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0 730	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on August 5, 2021. R1 discharged on February 13, 2026. R1's records included a progress note dated February 13, 2026, but lacked a discharge summary to include; - identifying information, including the resident's date of birth, and telephone number; - the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; - names, addresses, and telephone numbers of the resident's health and medical service providers, if known; - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; - the resident's advance directives, if any; - copies of any health care directives, guardianships, powers of attorney, or conservatorships; - all records of communications pertinent to the resident's services;	0 730			

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0 730	Continued From page 13 - 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; - 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; - documentation that the resident has received and reviewed the assisted living bill of rights; - documentation of complaints received and any resolution; - a discharge summary, including service termination notice and related documentation, when applicable; and - other documentation required under this chapter and relevant to the resident's services or status. R5 R5 was admitted to the licensee and began receiving services on October 19, 2022. R5 discharged on January 6, 2025. R5's records included a progress note dated January 6, 2025, but lacked a discharge summary to include; - identifying information, including the resident's date of birth, and telephone number; - the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; - names, addresses, and telephone numbers of the resident's health and medical service providers, if known; - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730			

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0 730	Continued From page 14 documentation, and other relevant health records; - the resident's advance directives, if any; - copies of any health care directives, guardianships, powers of attorney, or conservatorships; - all records of communications pertinent to the resident's services; - 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; - 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; - documentation that the resident has received and reviewed the assisted living bill of rights; - documentation of complaints received and any resolution; - a discharge summary, including service termination notice and related documentation, when applicable; and - other documentation required under this chapter and relevant to the resident's services or status. On May 13, 2026, at 7:28 a.m., clinical nurse supervisor (CNS)-D acknowledged the discharge summary was lacking information and stated, "It would appear that we are not including all the items in our note to cover the items needed for a discharge summary. I will have to look into that. ." The Licensee's Discharge Summary policy, dated May 30, 2023, indicated the discharge summary would include the above-mentioned items. No further information was provided.	0 730			

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0 730	Continued From page 15	0 730			
	TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days				
0 775 SS=I	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 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			

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0 780	Continued From page 16	0 780			
0 780 SS=F	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; 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.	0 780			

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0 780	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 18 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). The findings include: Please refer to the document titled, Physical	0 810			

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0 810	Continued From page 19 Environment Inspection Report (PEIR) dated May 12, 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 (BGS) was submitted and a clearance received in affiliation with the assisted living with dementia care licensee's current health facility identification (HFID) for two of fifty four employees (Life enrichment coordinator (LEC-I and administrator assistant AA-J).	01290			

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01290	Continued From page 20 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: LEC-I LEC-I was hired on June 5, 2024, to perform administrative duties for the licensee's residents and staff. LEC-I's employee record contained a background study dated affiliated with a separate location operated by the licensee's owner under HFID license 32681. LEC-I's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID license 34299, effective August 1, 2021. AA-J AA-J was hired on January 17, 2024, to perform life enrichment activities with the residents. AA-J's employee record contained a background study dated affiliated with a separate location operated by the licensee's owner under HFID license 32681. AA-J's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID license 34299, effective August 1, 2021. On May 12, 2026, at 12:56 p.m., licensed assisted living director (LALD)-C acknowledged the two staff were not affiliated to HFID 34299	01290			

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01290	Continued From page 21 and stated, "[LEC-I] was at out Hutchinson location so she might need to be affiliated, [AA-J] also might need to be affiliated, we can get that done, I wasn't aware." The licensee's Background Checks policy, dated May 30, 2026, indicated, "All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through OHS. Only those with satisfactory results will continue to work with the facility and its residents." No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290			
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as staff members of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on interview and record review the	01310			

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01310	Continued From page 22 licensee failed to ensure a licensed practical nurse (LPN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of two licensed practice nurse employees (LPN-K), which had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 11, 2026, at 10:45 a.m., assisted living director (LALD)-C stated there were a total of two LPNs employed by the licensee. LPN-K was hired on November 14, 2023, to perform direct care services to residents. LPN-K's employee record contained documentation to show that LPN-K received a Minnesota LPN license on May 25, 2018. During record review on May 11, 2026, at 1:20 p.m., regional registered nurse (RRN)-A 's stated, "We have something we need to self-report, we have a nurse that's license expired on February 28. She is not working and obviously we won't allow her to work now that we know, but we just found out today that she was working without a license as she worked in March and she didn't go	01310			

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01310	Continued From page 23 on a leave of absence until April. We did look at what nursing things she would have done while working with an expired license and it looks like she did give an injection." On May 11, 2026, at 1:35 p.m., surveyor observed the Minnesota Board of Nursing website to show LPN-K's Minnesota LPN license was expired effective February 28, 2026. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted 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	01620			

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01620	Continued From page 24 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 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 change of condition assessments and ongoing nursing assessments not to exceed every 90-days thereafter for one of four residents (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	01620			

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01620	Continued From page 25 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 and began receiving assisted living services on November 24, 2025. R4's record included a Residency Agreement signed by R4's legal representative on November 24, 2025. R4's Service Plan, dated April 29, 2026, indicated R4's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, blood glucose monitoring, medication administration and meal assistance. R4's record included a change of condition assessment dated January 23, 2026 and a quarterly assessment dated April 28, 2026, which indicated 95 days had passed since R4's last assessment. R4's record also included a progress note dated March 30, 2026 that indicated R4 had been hospitalized from March 14, 2026, through March 27, 2026, indicating no change of condition assessment had been completed after R4's return from a hospital stay. On May 13, 2026, at 7:30 a.m., clinical nurse supervisor (CNS)-D acknowledged a change of condition assessment was not always being completed and stated, "Change of condition assessment is going to be needed any time they leave for a hospital, and they come back with a different order. Typically, our practice would be	01620			

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01620	Continued From page 26 only if they come back with something new, so depending on the time frame we would wait for the quarterly assessment to be done, because they go together, typically I will write quarterly or change of condition but in this case I may not have." On May 13, 2026, at 7:39 a.m., CNS-D acknowledged assessments were not always completed within 90 days and stated, "Every 90 days an assessment should be done, I don't know off the top of my head if they can be late, that is a good question, it would probably be good for me to know if there is wiggle room or if 90 days is the time frame I don't know that I was ever taught on that." The licensee's Initial and On-Going Nursing Assessment of Residents policy, dated June 1, 2023, indicated, "The RN will re-assess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. The RN will reassess the resident if the resident has a change in condition." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01750 SS=F	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:	01750			

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01750	Continued From page 27 (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 specific medication administration instructions for each resident were documented in the resident's record for three of three residents (R2, R3, and 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 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: R2 R2 was admitted to the licensee and started receiving assisted living services August 26, 2025. R2's diagnoses included a traumatic brain injury, obstructive sleep apnea, and type 2 diabetes. R2's Service Plan dated January 28, 2026, indicated R2 received assistance with bathing,	01750			

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01750	Continued From page 28 grooming, nail care, housekeeping, medication administration, vitals, blood glucose monitoring, and oxygen assist. R2's medication administration record dated May 1, 2026, through May 31, 2026, included Lantus 18 units every morning, oxygen 4 liters at bedtime, and Senna plus 8.6-50 milligrams (mg) take one tablet by mouth twice a day. R3 R3 was admitted and began receiving assisted living services on March 10, 2025. R3's record included a Residency Agreement signed by R3 on March 10, 2025. R3's diagnoses included type 2 diabetes, hypertension, and autism. R3's Service Plan dated March 10, 2025, indicated R3 received assistance with dressing, medication administration, bathing, continence care, blood glucose monitoring, and grooming. R3's medication administration record dated May 1, 2026, through May 31, 2026, included Simlandi 40 mg/ 0.4 milliliters (ml) R4 R4 was admitted and began receiving assisted living services on November 24, 2025. R4's record included a Residency Agreement signed by R4 on November 24, 2025. R4's Service Plan, dated April 29, 2026, indicated R4's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, blood glucose monitoring, medication	01750			

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01750	Continued From page 29 administration and meal assistance. R4's medication administration record dated May 1, 2026, through May 31, 2026, included Spiriva 2.5 micro grams (mcg) inhale 2 puffs by mouth one time daily, nystatin powder, apply to affected area(s) three times a day, incruise 62.5 mcg inhale 1 puff by mouth daily, and acetaminophen 1000 mg four times daily for pain. R2, R3, and R4's records lacked specific medication administration instructions for each resident. On May 13, 2026, at 8:59 a.m., clinical nurse supervisor (CNS)-D stated, "We do not have a policy for parameters, and I think if they don't have parameters going forward we will train that if an order needs parameters and it doesn't come with it then we will request them." The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated June 20, 2023, indicated, "Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment, and therapy, and the unlicensed personnel have demonstrated the ability to competently follow the procedures; and the RN has developed written, specific instructions for each resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760			

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01760	Continued From page 30 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 document administration or refusal of medications according to provider orders for one of four residents (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 and began receiving assisted living services on November 24, 2025. R4's record included a Residency Agreement signed by R4 on November 24, 2025.	01760			

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01760	Continued From page 31 R4's Service Plan, dated April 29, 2026, indicated R4's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, blood glucose monitoring, medication administration and meal assistance. R4's medication administration record dated May 1, 2026, through May 31, 2026, had missing charting on May 9, 2026, for Lantus inject 40 units subcutaneously every twelve hours, as well as Novolog Flex pen sliding scale three times daily. There was no reason written for why the medications were not given. On May 13, 2026, at 7:43 a.m., clinical nurse supervisor (CNS)-D acknowledged documentation was not always being completed and stated, "So, [staff] want to make sure everything is clicked off, so if they have TED stockings and they don't have the supply they wouldn't write refused, we would write, no supply, if it is a medication they would write administered or refused. They are trained that everything should be clicked off in some form or fashion. Unfortunately, we don't have anything in place to go back and do an audit of the MAR (Medication administration record) that I am aware of or have been trained on." The licensee's Documentation of Medication, Treatment and Therapy Management Services policy, dated June 20, 2023, indicated, "RNs, LPNs, and ULPs will appropriately document all medications, treatments, and therapy management services provided to residents including documentation of PRN medications and documentation of requesting and receiving prescription refills."	01760			

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01760	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four 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 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: R4 was admitted and began receiving assisted living services on November 24, 2025. R4's record included a Residency Agreement signed by R4 on November 24, 2025. R4's Service Plan, dated April 29, 2026, indicated	01820			

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01820	Continued From page 33 R4's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, blood glucose monitoring, medication administration and meal assistance. R4's MAR (medication administration record) dated May 1, 2026, through May 31, 2026, included anti itch lotion apply to the effected area(s) as needed, and Gas relief tablets, chew and swallow one tablet by mouth every 6 hours as needed for flatulence. R4's record lacked doctors orders for anti itch lotion apply to the effected area(s) as needed, and Gas relief tablets, chew and swallow one tablet by mouth every 6 hours as needed for flatulence. On May 13, 2026, at 7:35 a.m., clinical nurse supervisor (CNS)-D stated, "Yes, we would want an order from the PCP (primary care provider) for anything, medications, treatments, we need to have orders for all of it, and we are working on getting orders for the items we have identified as not having orders for." On May 13, 2026, at 8:59 a.m., CNS-D stated, "We do not have orders for Robyn's TUMs and the anti-itch cream, we are working with her doctor to get those now." The Licensee's Medication and Treatment Orders: Receiving, Implementation, and Reordering policy, dated April 4, 2024, indicated, "All medication and treatments will have an appropriate prescriber order in the resident's record." No further information was provided.	01820			

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01820	Continued From page 34	01820			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months 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: During the entrance conference on May 11, 2026, at approximately 10:45 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided treatment or therapy management services for their residents. R2 was admitted to the licensee and started receiving assisted living services August 26, 2025.	01830			

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01830	Continued From page 35 R2's diagnoses included a traumatic brain injury, obstructive sleep apnea, and type 2 diabetes. R2's Service Plan dated January 28, 2026, indicated R2 received assistance with bathing, grooming, nail care, housekeeping, medication administration, vitals, blood glucose monitoring, and oxygen assist. R2's Service Delivery Record dated May 1, 2026, through May 31, 2026, indicated R2 received oxygen assistance on May 1, 5, 6, 8, 9, and 10, 2026. R2's record included a signed doctors order for nocturnal oxygen use dated December 10, 2024. R2's record lacked current doctors orders for oxygen use dated within the past 12 months. On May 13, 2026, at 7:35 a.m., clinical nurse supervisor (CNS)-D stated, "Yes, we would want an order from the PCP (primary care provider) for anything, medications, treatments, we need to have orders for all of it, and we are working on getting orders for the items we have identified as not having orders for." The Licensee's Medication and Treatment Orders: Receiving, Implementation, and Reordering policy, dated April 4, 2024, indicated, "At least every 12 months the resident's primary care provider will receive the current medication and treatment orders for the resident or more frequently if needed. The prescriber will review, sign, and return the medication and treatment orders." No further information was provided.	01830			

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01830	Continued From page 36	01830			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01910 SS=F	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to 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 for two of two discharged residents (R1 and R5).	01910			

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01910	Continued From page 37 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on August 5, 2021. R1 discharged to another facility on February 13, 2026. R1's Service Plan dated August 20, 2024, indicated R1 received medication administration services. R6 R6 was admitted to the licensee and began receiving services on January 26, 2023. R6 discharged to another facility on March 20, 2025. R6's Service Plan, signed August 3, 2022, indicated R6 received medication administration services. R1 and R5's record lacked a medication disposition to include including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of	01910			

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01910	Continued From page 38 staff and other individuals involved in the disposition On May 12, 2026, at 10:42 a.m., regional registered nurse (RRN)-A stated, "We don't yet have a disposition of medications for [R1], we are still looking, as for [R6] records we have everything except a disposition of meds." On May 13, 2026, at 7:28 a.m., clinical nurse supervisor (CNS)-D stated, "We need an order for them to discharge and send the meds, from a nursing stand point we would fill out a med disposition and destruction and the MN roster discharge and all the applicable information in them and a discharge note. It would appear that we are not including all the items in our note to cover the items needed for a discharge summary. I will have to look into that." The licensee's Disposition or Disposal of Medication policy, dated June 20, 2023, indicated, "Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	01960			

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NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388			
(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
01960	Continued From page 39 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of two residents (R2) reviewed who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee and started receiving assisted living services August 26, 2025. R2's diagnoses included a traumatic brain injury, obstructive sleep apnea, and type 2 diabetes. R2's Service Plan dated January 28, 2026, indicated R2 received assistance with bathing, grooming, nail care, housekeeping, medication administration, vitals, blood glucose monitoring, and oxygen assist.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388			
(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
01960	Continued From page 40 R2's Service Delivery Record dated May 1, 2026, through May 31, 2026, indicated R2 received CPAP assist May 3, 4, and 8 2026, and services were canceled on May 2, 5, 6, 9, and 10, 2026. R2's record lacked any documentation for CPAP assist on May 1, 7, and 11, 2026. On May 13, 2026, at 7:43 a.m., clinical nurse supervisor (CNS)-D acknowledged documentation was not always being completed and stated, "So, [staff] want to make sure everything is clicked off, so if they have TED stockings and they don't have the supply they wouldn't write refused, we would write, no supply, if it is a medication they would write administered or refused. They are trained that everything should be clicked off in some form or fashion. Unfortunately, we don't have anything in place to go back and do an audit of the MAR (Medication administration record) that I am aware of or have been trained on." The licensee's Documentation of Medication, Treatment and Therapy Management Services policy, dated June 20, 2023, indicated, "RNs, LPNs, and ULPs will appropriately document all medications, treatments, and therapy management services provided to residents including documentation of PRN medications and documentation of requesting and receiving prescription refills." No further information provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388		
(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
01970	Continued From page 41	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R4) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 11, 2026, at approximately 10:45 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided treatment or therapy management services for their residents. R4 was admitted and began receiving assisted living services on November 24, 2025.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388		
(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
01970	Continued From page 42 R4's record included a Residency Agreement signed by R4 on November 24, 2025. R4's Service Plan, dated April 29, 2026, indicated R4's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, blood glucose monitoring, medication administration and meal assistance. R4's MAR (medication administration record) dated May 1, 2026, through May 31, 2026, included anti itch lotion apply to the effected area(s) as needed, and Gas relief tablets, chew and swallow one tablet by mouth every 6 hours as needed for flatulence. On May 13, 2026, at 7:35 a.m., clinical nurse supervisor (CNS)-D stated, "Yes, we would want an order from the PCP (primary care provider) for anything, medications, treatments, we need to have orders for all of it, and we are working on getting orders for the items we have identified as not having orders for." The Licensee's Medication and Treatment Orders: Receiving, Implementation, and Reordering policy, dated April 4, 2024, indicated, "All medication and treatments will have an appropriate prescriber order in the resident's record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388		
(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
02310	Continued From page 43 (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 standards, medical or nursing standards for one of one resident (R8) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 12, 2026, at 7:50 a.m., surveyor observed an unsecured oxygen cylinder that was not stored properly in noncombustible racks in R8's room. R8 stated, "Yeah it just always sits over there like that, I don't have anything for it to go in." On May 13, 2026, at 7:38 a.m., clinical nurse supervisor (CNS)-D stated, "Oxygen should always be in some type of cart or carrying devise and it should be upright and not laying. I will need to look into why his isn't." Minnesota Department of Health (MDH) Oxygen	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388		
(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
02310	Continued From page 44 Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
03090 SS=F	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT WATERTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 409 JEFFERSON AVENUE SW WATERTOWN, MN 55388			
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03090	Continued From page 45 The findings include: On May 11, 2026, at 11:30 a.m., the surveyor observed during the facility tour, no electronic monitoring notice posted in the facility with the statutory required language. On May 13, 2026, at 9:20 a.m., licensed assisted living director (LALD)-C acknowledged the lack of signage with the required statutory language and indicated, "Unfortunately, we don't have anything in place for that so we will need to get something put up. Electronic monitoring." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Page: 1

Establishment Info

River Oaks at Watertown
409 JEFFERSON AVENUE SW
Watertown, MN 55388
Carver County
Parcel:

Phone:

License Info

License: HFID 34299

Risk:
License:
Expires on:
CFPM: GARY EDWARD EDER
CFPM #: FM62842; Exp: 10/29/2028

Inspection Info

Report Number: F8087261102
Inspection Type: Full - Single
Date: 5/12/2026 Time: 2:00:00 PM
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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER GARY EDWARD EDER AND HRD NURSE SURVEYOR TESA BROWN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND HRD NURSE SURVEYOR.

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 F8087261102 from 5/12/2026

John Boettcher

GARY EDWARD EDER
KITCHEN MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

River Oaks at Watertown
Watertown
County/Group: Carver County

Inspection Info

Report Number: F8087261102
Inspection Type: Full
Date: 5/12/2026
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Walk-in Cooler at 34 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: HB EGG; Temperature Process: Cold-Holding

Location: Walk-in Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT; Temperature Process: Cold-Holding

Location: Walk-in Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Walk-in Freezer at -4 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 39 Degrees F.

Comment: KITCHEN

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment: KITCHEN

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment: SATELLITE KITCHEN

Violation Issued?: No

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

Location: Upright Cooler at 38 Degrees F.

Comment: SATELLITE KITCHEN

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CREAM CHEESE; **Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: SATELLITE KITCHEN
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SAUSAGE; **Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: SATELLITE KITCHEN
Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
River Oaks at Watertown Watertown County/Group: Carver County	Report Number: F8087261102 Inspection Type: Full Date: 5/12/2026 Time: 2:00:00 PM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 179 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34299016	Date: 5/12/2026
Facility Name: River Oaks of Watertown	
Facility Address: 409 Jefferson Ave. SW, Watertown, MN 55388	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: A marked exit door led to an egress path which led to a gate in the center courtyard. The gate was not readily openable from the egress side. The gate was locked with a sliding bolt lock on the ingress side of the gate that was not easily observed or operated from the egress side of the gate. The unapproved locking mechanism should be removed, and the gate should be maintained free of hardware that would obstruct egress.

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

Comments:

A marked exit door led to an egress path which led to a gate in the center courtyard. The center courtyard of the building was completely enclosed and there was no path to the public right of way without having to reenter the building. Facility staff stated that the center courtyard was not an area of refuge and that the egress routes should not lead to the courtyard. Egress routes should be reviewed and approved for code compliance by the local authority and the Department of Labor and Industry. The licensee should follow requirements for approved egress routes.

The marked exit door in the water heater room was obstructed by several items including a floor machine, ladders and other stored maintenance items. The path of egress should be maintained free of storage or obstructions to ready access in an emergency.

4. 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: The facility lacked proper carbon monoxide (CO) detection. Single station CO alarms were present near several sources of CO but were not tied into building fire alarm system. No CO detection was present near other sources of CO such as gas fireplace in the front lobby. The annual fire alarm report confirmed that no CO detection devices were connected to the system. CO alarms were not installed within 10 feet of bedrooms or within dwelling units. Proper CO detection should be installed and maintained in the facility to protect occupants.

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

Comments: A significant amount of discarded cigarette butts were located on the ground in the courtyard area and in front of the facility. Cigarettes and other smoking materials should be disposed of in approved receptacles. Improperly discarded cigarette butts on the ground should be picked up and the area maintained free of improperly discarded smoking materials which may pose a fire hazard.

6. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or 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: The supplied hardwired smoke alarms were all past 10 years from date of manufacture in resident rooms in the unsprinklered portion of the building referred to as the "apartments." Hardwired alarms that exceed 10 years of age should be replaced with newer hardwired smoke alarms and maintained in working condition. All provided alarms within the apartment units should interconnect such that when one is activated, all alarms within that unit sound.

7. 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: The sprinkler heads in the basement records room did not have proper clearance with stacked boxes of paper stored such that they may obstruct proper waterflow. The proper clearance around sprinkler heads should be maintained to ensure proper operation of sprinkler heads in an emergency.

8. 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:

The information panel displaying generator condition indicated several issues with the generator. The licensee failed to provide any documentation of testing or inspection on the generator. The licensee indicated that they do not conduct any testing and were not able to confirm the generator was in a proper working condition. The generator should be brought to proper working condition and maintained with required testing and inspection.

The Ansul system in the kitchen of the facility had been red tagged by a fire protection company indicating it was not in proper condition. The system should be repaired and maintained in proper working order.

Controlled egress keypads and door locking hardware were installed but not in use on all exit doors in the facility. Controlled egress hardware should be disabled and removed where not in use to avoid confusion or locking malfunction.

An escutcheon was missing around the sprinkler head in resident room 1.

Neither of the sprinkler system standpipes had a hydraulic information placard attached to the system riser displaying required information. Placards should be supplied and maintained with all relevant data and information on the system.

The nurse station housekeeping closet had some penetrations properly covered with fire rated caulking, but there were other penetrations for plumbing and conduit that were not properly covered and left holes in the fire rated wall construction. Unsealed penetrations should be sealed by approved means.

Fire door and fire door frame rating placards were painted over on several fire door assemblies throughout the building. Fire rating information placards should be maintained legible and free of paint or other substances.

9. Gas fired commercial cooking appliances installed on casters and appliances that are moved for cleaning and sanitation purposes shall be connected to the piping system with a connector complying with ANSI Z21.69. Movement of appliances on casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 607.4]

Comments: The kitchen stove was not tethered by a required restraining device. An appropriate device should be installed and maintained on the gas stove in the kitchen.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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: The smoke alarms installed in the "apartment" units were not properly interconnected. All smoke alarms provided within each unit should be interconnected such that if any alarm is activated, all other alarms with the unit will sound. Smoke alarms should be properly interconnected, and the interconnection should be maintained.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. 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 licensee failed to provide adequate documentation of evacuation drills. Only two evacuation drills were documented in 2025. Evacuation drills should occur at least twice per shift per year and at least once every other month.

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 licensee failed to document unique residents' needs for evacuation. Fire safety and evacuation plans should include unique needs for resident evacuation.