Electronically Delivered

March 20, 2026

Licensee
Diamond Willow Assisted Living
8583 Unity Drive
Mountain Iron, MN 55768

RE: Project Number(s) SL24664016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

(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: SL24664016-0 On February 24, 2026, through February 26, 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 25 residents; 25 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a locking system for a resident room for one of 25 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 February 24,	0 460		

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0 460	Continued From page 2 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with the current assisted living laws and regulations. R2's diagnoses included dementia, psychotic and mood disturbances, and anxiety. During a medication administration observation February 25, 2026, at 7:07 a.m., the surveyor observed R2's door had a circular hole in the door and R2's lock on the door had been removed. R2's door lacked a lock on the door handle or other locking system on R2's door. R2's Service Plan dated August 7, 2024, indicated R2 received the following services: assistance with medications, dressing, grooming, transferring, bed mobility, bathing, housekeeping and laundry. In addition, R2's Service Plan indicated R2 received the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) on August 7, 2024, that indicated the licensee provided locking systems including resident rooms. R2's record respectfully lacked documentation for the reason why R2's lock on R2's door had been removed or permission from R2 or R2's resident's representative for the removal of the lock. On February 26, 2026, at 8:58 a.m., LALD/CNS-A stated R2 had a history of hallucination, paranoia, and delusions seeing people in her room trying to hurt R2, so R2 would constantly lock the door and the licensee was worried about R2's safety. LALD/CNS-A stated LALD/CNS-A would look for documentation in R2's record conversations with R2's representative and verbal consent. At 10:07 a.m. the LALD/CNS-A stated LALD/CNS-A was	0 460		

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0 460	Continued From page 3 unable to find documentation in R2's record any conversation regarding the removal of R2's door lock. LALD/CNS-A stated there should have been documentation in R2's care plan, progress notes and assessments to support the removal of R2's door lock. The licensee's Minnesota Bill of Rights for Assisted Living dated January 1, 2026, indicated residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. One staff member with a specific need to enter the unit shall have keys, this right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	0 460		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and	0 480		

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0 480	Continued From page 4 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 6 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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of two employees (unlicensed personnel (ULP)-C, ULP-F). In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable medical equipment for one of one employee (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 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: HAND HYGIENE WITH GLOVE USE R4's Service Plan dated December 23, 2025, indicated R4 received the following services: assistance with dressing, bathing, grooming, toileting, transferring, bed mobility, housekeeping, and laundry.	0 510		

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0 510	Continued From page 7 On February 25, 2026, at 10:15 a.m., the surveyor observed ULP-C and ULP-F enter R4's room and complete morning cares for R4's. Without performing hand hygiene, ULPs put on gloves and ULP-C cleansed R4's peri cares, both ULPs removed R4's used brief, repositioned R4, and ULP-C washed R4's buttock area. With the same gloves, ULP-C applied a barrier cream to R4's buttocks, groin and around R4's belly button. ULP-C removed gloves, washed hands, put on a new pair of gloves and proceeded to assist ULP-F in changing R4's top and pants, then positioned the Hoyer (mechanical transfer equipment) sling around R4 and transferred R4 into the anti-rollback wheelchair. Both ULPs removed gloves, ULP-F washed hands, put on a clean pair of gloves and assisted R4 with hair care while ULP-C made R4's bed. DISINFECTING SHARED EQUIPMENT On February 26, 2026, at 9:00 a.m., the surveyor observed ULP-G obtain the facilities blood pressure cuff, oximeter (measures blood oxygen level), and tympanic thermometer from a three-tier cart and monitored a female resident's blood pressure with readings of 127/68, temperature 97.4 and 98% oxygen saturation. ULP-G placed the shared equipment back into the basket, without disinfecting the equipment after use and documented vital sign results. ULP-G stated ULP-G did not disinfect the vital signs equipment before or after use. ULP-G stated disinfecting wipes were not readily available and were locked in the laundry room cupboard. On February 26, 2026, at 8:58 a.m., LALD/CNS-B stated staff should be disinfecting shared equipment after use and disinfecting wipes were	0 510		

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0 510	Continued From page 8 kept in the cupboard in the locked laundry room. LALD/CNS-A stated after performing personal cares, staff should change gloves, perform hand hygiene and put on another pair of gloves before applying ointments or proceeding with resident cares. The licensee's Hand washing policy dated January 1, 2025, indicated hand washing shall be completed after changing diapers, or cleaning up after someone had used the toilet, between tasks and procedures. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The licensee's Cleaning of Shared Medical Equipment policy dated January 1, 2025, indicated the licensee would implement and maintain a process to ensure all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the	0 775		

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0 775	Continued From page 9 physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	0 810		

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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
0 810	Continued From page 11 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;	01060		

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01060	Continued From page 13 (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and/or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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01060	Continued From page 14 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 February 24, 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with the current assisted living laws and regulations. R1's diagnoses included dilatated cardiomyopathy, adult failure to thrive, malignant neoplasm of prostate and atrial fibrillation. R1's Discharge Summary dated January 20, 2026, indicated R1 started services on December 23, 2025, and was hospitalized on January 8, 2026, due to a decline in health. R1 passed away at the hospital on January 15, 2026. R1's record lacked documentation a written notice was provided to the resident and or representative that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the OOLTC; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 15 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On February 24, 2026, at 2:43 p.m., LALD/CNS-A stated she was unable to find documentation in R1's records a written notice had been provided, or the ombudsman was notified. LALD/CNS-A stated normally the information would be documented in the resident's record if it was completed. The licensee's 1.23 Emergency Relocation policy dated October January 1, 2025, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, and to the OOLTC if the resident has not returned to the facility in four days that contains, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the OOLTC; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal; -the facility must provide contact information for the agency to which the resident may submit an appeal; and	01060		

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01060	Continued From page 16 -the Office of Ombudsman for Long-Term Care would be notified if the resident had been relocated and not returned and has returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760		

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01760	Continued From page 17 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 February 24, 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services for the residents at the facility. ULP-E's employee record indicated ULP-E received training in medication administration and demonstrated competency to LALD/CNS-A on September 9, 2025. R3's diagnoses included dementia, psychotic and mood disturbances and anxiety. R3's Service Plan-Addendum to Contract effective dated August 7, 2024, indicated R3's services included medication administration three times per day. R3's Medication Admin Summary dated February 1, 2026, through February 25, 2026, indicated R3 was scheduled and received the following medications: -acetaminophen 500 milligrams (mg) two tablets for left hip pain; -Depakote (divalproex) 125 mg three times a day and indicated "DO NOT CRUSH" for behavioral disturbances; -gabapentin (Neurontin) 100 mg with meals for dementia; and	01760		

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01760	Continued From page 18 -vitamin D 2000 units (U) two tablets for supplementation. R3's prescriber orders dated July 8, 2025, included orders noted above. On February 25, 2026, at 8:23 a.m., the surveyor observed ULP-E prepare and administer R3's medications. ULP-E dispensed medications into a clear plastic medication cup then removed the Neurontin capsule and placed it to the side. ULP-E stated capsules were unable to be crushed so ULP-E would open have to open the capsule instead of crushing. ULP-E crushed acetaminophen, divalproex (which indicated "DO NOT CRUSH") and vitamin D tablets into a powdery substance. ULP-E opened the Neurontin capsule and poured the medication powder into the crushed medications, mix the medications with applesauce and administered to R3 at the breakfast table. ULP-E proceeded and documented R3's medications administered. On February 26, 2026, at 9:43 a.m., LALD/CNS-A stated staff should be following the instructions on the resident's medication administration record when administering medications. LALD/CNS-A reviewed R3's February 2026, Med Admin Summary and stated R3's instruction for Depakote instructed not to crush medication. On February 26, 2026, at 10:07 a.m., LALD/CNS-A stated LALD/CNS-A stated LALD/CNS-A sent a request to R3's provider to obtain a liquid form of Depakote. The manufacturer's instructions for Depakote dated October 20211, indicated Depakote should be swallowed whole and should not be crushed.	01760		

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01760	Continued From page 19 The licensee's Medication and Treatment-Administration and Delegation policy dated January 1, 2025, indicated the registered nurse (RN) must instruct the ULP on the following medication administration tasks before delegating the task to them to include: -the complete procedure of checking the resident's medication administration record (MAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerators. 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	01880		

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01880	Continued From page 20 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 24, 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication storage for the residents at the facility. On February 24, 2026, at 11:38 a.m., the surveyor reviewed the medication refrigerator located on Leonidas Suites with LALD/CNS-A and observed the internal thermometer temperature reading of 32 degrees Fahrenheit (F). LALD/CNS-A stated staff monitor the refrigerator temperatures daily and record results in Residex (web-based health electronic record system). The licensee's Temp-Med Room Refrigerator history report dated December 26, 2025, to February 25, 2026, lacked written temperature ranges for proper storage to ensure medication quality and safety. In addition, the temperature logs indicated 30 out of 45 recorded temperatures were below 36 degrees F, which is at risk for freezing. On February 26, 2026, at 9:45 a.m., the surveyor reviewed the medication refrigerator content with unlicensed personnel (ULP)-C and confirmed the internal thermometer temperature reading was 32 degrees F and the following medications were being stored: -R2 and R5's unopened bottles of latanoprost (Xalatan) eye drops (used to treat increased eye pressure).	01880		

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01880	Continued From page 21 On February 26, 2026, at 10:07 a.m., LALD/CNS-A reviewed the recorded refrigerator temperature logs and confirmed several temperatures were out of range and lacked specific temperature ranges. The manufacturer's instructions for use of latanoprost eye drop dated August 2011, indicated to store unopened bottle(s) under refrigeration at 36 F to 46 F. The licensee's Medication Storage policy dated January 1, 2025, indicated medications managed by the licensee would be securely stored per manufacture directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for three of four medication carts (Leonidas Suites	01890		

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01890	Continued From page 22 cart #1 and #2, Wacoutah Suites cart #4). 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 February 24, 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication storage for residents at the facility. LEONIDAS SUITES On February 24, 2026, at 11:40 a.m., the surveyor reviewed the medication cart #1 with LALD/CNS-A and observed the following: -R5's opened bottle of latanoprost (used to treat increased eye pressure) 0.005% eye drop lacked the date the eye drop had been opened and when the eye drop would expire. At 11:43 medication cart #2 was reviewed with LALD/CNS-B and observed the following: -R2's two opened bottles of latanoprost 0.005% eye drop lacked the date the eye drops had been opened and when the eye drops would expire. Immediately following the medication cart observation, LALD/CNS-A stated the nurses reviewed the medications cart weekly and LALD/CNS-A completed routine audits but had not been completed recently.	01890		

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01890	Continued From page 23 WACOUTAH SUITES On February 24, 2026, at 11:28 a.m., the surveyor reviewed the medication cart #4 with unlicensed personnel (ULP)-C and observed the following: -R6's opened bottle of latanoprost 0.005% eye drop lacked the date the eye drop had been opened and when the eye drop would expire. In addition, R6 had an additional latanoprost eye drop that lacked a legible prescription label with the name of the residents and instructions for administration. ULP-C verified the prescription label was worn and unable to read and stated the latanoprost belonged to R6 and R6 received eyes drop daily. ULP-C stated the opened dated can be written on the medication with a sharpie or the licensee had stickers to put on medication with opened and expiration dates. ULP-C stated they have not been instructed to date eye drops when opened only insulins. The manufacturer's instructions for use of latanoprost eye drop dated August 2011, indicated once the eye drop bottle is opened for use, it may be stored at room temperature up to eight weeks. The licensee's Medication Storage policy dated January 1, 2025, indicated medications managed by the licensee would be securely stored per manufacture directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01890		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Diamond Willow Assisted Living
8583 Unity Drive
Mountain Iron, MN 55768
St Louis County
Parcel:

Phone:

License Info

License: HFID 24664

Risk:
License:
Expires on:
CFPM: Gage Soriano-Mancia
CFPM #: 116265; Exp: 4/1/2026

Inspection Info

Report Number: F1032261045
Inspection Type: Full - Single
Date: 2/24/2026 Time: 10:34:54 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 7
Total Priority 3 Orders: 3
Delivery:

New Order: 2-100 Supervision
2-102.11D,E,F,G,H,I *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.
COMMENT: All staff in LEONIDAS building could not answer any basic food safety questions including cook temps, cold holding temps or basic sanitation. train staff.

staff was unaware of pasteurized egg requirement

staff did not know how to cool food properly
Comply By: 3/26/2026 Originally Issued On: 2/24/2026

New Order: 2-100 Supervision
2-102.11JKLMO *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.
COMMENT: staff in LEONIDAS is untrained and did not know they could not use wooden utensils, deep cut cutting boards, did not know how to test the dishwasher temperature, or know what was sanitizing the dishes
Comply By: 3/26/2026 Originally Issued On: 2/24/2026

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: beef stew left in large pot with lid on. cool in shallow pans with lid off
Comply By: Complied On Site Originally Issued On: 2/24/2026

New Order: 3-500A Microbial Control: cooling
3-501.15B *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.
COMMENT: cool with covers off
Comply By: Complied On Site *Originally Issued On: 2/24/2026*

! **New Order: 3-800 Highly Susceptible Population**
3-801.11B *Priority Level: Priority 1 CFP#: 26*
MN Rule 4626.0447B Discontinue using unpasteuerized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages and except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined, when serving a highly susceptible population.
COMMENT: eggs need to be pasteurized. discontinue serving un-pasteurized eggs.
Comply By: 2/27/2026 *Originally Issued On: 2/24/2026*

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: remove all wooden spoons and wooden handled utensils.

discontinue reusing yogurt containers and other food containers not designed to store food properly
Comply By: 3/6/2026 *Originally Issued On: 2/24/2026*

New Order: 4-200 Equipment Design and Construction
4-201.11 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.
COMMENT: replace all damaged and wooden utensils
Comply By: 3/6/2026 *Originally Issued On: 2/24/2026*

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: provide test kit for the dishwasher for the LEONIDAS building
Comply By: 3/6/2026 *Originally Issued On: 2/24/2026*

New Order: 4-500 Equipment Maintenance and Operation
4-501.112A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.
COMMENT: dishwasher took several runs to get to temperature. ensure you are checking the internal temperature and have both dishwashers serviced.
Comply By: 3/6/2026 *Originally Issued On: 2/24/2026*

New Order: 4-500 Equipment Maintenance and Operation
4-501.12 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.
COMMENT: remove old and deeply scratched cutting boards
Comply By: 3/6/2026 *Originally Issued On: 2/24/2026*

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: drying rack needs to be cleaned and sanitized twice a day. Organic material on drying rack, clean
Comply By: 3/2/2026 *Originally Issued On: 2/24/2026*

Food & Beverage General Comment

Report reviewed with Gage. Potential hazards in day-to-day operation were discussed, including employee illness, excluding/restricting employees experiencing illness symptoms, recording employee illness symptoms

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 Duluth District Office inspection report number F1032261045 from 2/24/2026

Establishment Representative

Ben Kubes,
Public Health Sanitarian 3
218-302-6194
ben.kubes@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Diamond Willow Assisted Living
Mountain Iron
County/Group: St Louis County

Inspection Info

Report Number: F1032261045
Inspection Type: Full
Date: 2/24/2026
Time: 10:34:54 AM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Ambient Air
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Ambient Air
Location: Upright Cooler 2 at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler 2 at 40 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL24664016-0	**Date:** FEBRUARY 25, 2026
Facility Name: DIAMOND WILLOW ASSISTED LIVING	
Facility Address: 8583 UNITY DRIVE, MOUNTAIN IRON, MN 55768	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: There was a controlled egress locking system installed on all emergency exit doors in the Leonidas and Wacoutah buildings and on the exterior doors in the link. To exit the building using the link, occupants had to pass through two controlled egress doors.

3. 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: Carbon monoxide detectors were installed in the mechanical rooms of the Leonidas and Wacoutah buildings. There were gas fireplaces in the living/dining rooms of these buildings. Single station carbon monoxide alarms were installed in the living/dining rooms that were not part of the fire alarm system. Carbon monoxide alarms were not installed within ten feet of all resident bedrooms.

4. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: The fire alarm inspection reports dated October 3, 2025, indicated the supervisory tamper switches and initiating waterflow switches were not tested in the past year for the Leonidas and Wacoutah buildings.

5. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: Lint had accumulated behind the clothes dryer in the Leonidas building laundry room.

6. Lighted matches, cigarettes, cigars or other burning objects 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: Burnt cigarettes had been disposed of on the ground in the designated smoking area outside the Leonidas building.

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

   Comments: An extension cord was used to supply power to personal electronics in resident room two in the Wacoutah building. Improper use of extension cords creates a fire hazard.

☒ **TAG IDENTIFICATION: 0800**

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

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - The light bulb was not working in the exhaust fan fixture in the Leonidas building tub room.
   - The bathroom exhaust fan was not working in resident room seven in the Leonidas building. Bathroom exhaust fans shall be maintained in working order to remove excess moisture.
   - The light bulb was not working in the bathroom exhaust fan fixture in resident room ten in the Leonidas building.
   - There was a hole in the wall behind the door in resident room two in the Wacoutah building.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments:
   - Number identifiers were not posted at the doors for resident rooms three and four in the Leonidas building.
   - The number identifier posted at the door was not accurate for resident room ten in the Wacoutah building.
   Accurate number identifiers need to be posted at resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency.

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

   Comments: The fire safety and evacuation plan (FSEP) 9.06 fire policy inaccurately referenced fire doors on magnetic door holders and smoke compartments were referenced but not identified. The licensee failed to develop and maintain the fire safety and evacuation plan with site specific employee actions.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the past twelve months from the licensee. These FSEP training records were not provided. The licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had been completing tabletop fire drills and thought this met FSEP training requirements. The licensee failed to conduct site specific FSEP training with employees at least twice per year.

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

   Comments: The surveyor requested records for employee evacuation drills completed in the past twelve months from the licensee. Four fire drills were recorded in 2025, conducted in January, April, November, and December. The shift or time was not recorded on the May, November, and December drill

documentation. The simulated fire drill conditions were not recorded on the January or November documentation. The licensee failed to conduct evacuation drills at the required frequency, and the fire drill records were lacking the required information.