



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 13, 2026

Licensee
Autumn Lane Inc
36858 Pincherry Road
Cohasset, MN 55721

RE: Project Number(s) SL23725016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 8, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

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

Autumn Lane Inc

May 13, 2026

Page 3

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/Bm5uQEpHVva>. 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 "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER AUTUMN LANE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 36858 PINCHERRY ROAD COHASSET, MN 55721		
(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: SL23725016-0 On April 6, 2026, through April 8, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on April 7, 2026, issued at a widespread scope and level three (I) for tag identification 1290; the licensee took mitigating action on April 8, 2026, however, the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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

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0 480	Continued From page 3	0 480			
0 550 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550			

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0 550	Continued From page 4 The findings include: During a facility tour on April 6, 2026, at 12:10 p.m., with owner (O)-B, and observed the licensee's grievance procedure posted within the facility; however, lacked the required content to indicate the name, telephone number, and e-mail contact information for the individual(s) who were responsible for handling resident grievances. O-B stated O-B did not realize the contact information was missing from the grievance procedure and could easily add the information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual	0 630			

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0 630	Continued From page 5 abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included cerebral atherosclerosis, adult failure to thrive, diabetes, dementia, psychotic disorder, mood disorder and anxiety. R3's Service Plan (Waiver)- Addendum to Contract dated February 20, 2026, indicated R3's services included medication administration, dressing, grooming, toileting, bathing, skin cares, ambulation, transferring, housekeeping and laundry. On April 7, 2026, at 3:00 p.m., the surveyor observed unlicensed personnel (ULP)-F shave R3 with an electric razor while R3 was sitting in a chair in the upper level T.V. room with ULP-K. R3's IAPP dated March 5, 2026, indicated R3 was at risk to be abused and had no history of	0 630			

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0 630	Continued From page 6 risk of self-abuse; however, R3's assessment did not include an assessment of R3's risk of abusing other vulnerable adults. On April 8, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated CNS-C was aware of the required content in an IAPP assessments/evaluation. CNS-C reviewed R3's IAPP and stated R3's IAPP was missing the review of R3's risk of abusing others. CNS-C stated all the required content should be addressed in the IAPP since the licensee used Residex (electronic health record) for resident assessments and would have to contact Residex to help problem solve the issue. The licensee's Individual Abuse Prevention Pan policy dated August 1, 2021, indicated the licensee would develop and implement and individual abuse prevention plan for each vulnerable adult. All residents in an assisted living area are categorically considered vulnerable adults. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including: -other vulnerable adults; -the person's risk of abusing other vulnerable adults; and -statements or the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purpose of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

Minnesota Department of Health

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0 650	Continued From page 7	0 650			
0 650 SS=E	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 records contained the required content for two of four employees (unlicensed personnel (ULP)-F, ULP-K). 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	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 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: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-F ULP-F was hired on July 23, 2020, and effective August 1, 2021, began to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 3:00 p.m., the surveyor observed ULP-F shave R3 with an electric razor. ULP-F's employee record lacked annual performance reviews for 2024 and 2025. On April 8, 2026, at 12:19 p.m., LALD-A stated ULP-F was a part-time employee and didn't work frequently. LALD-A further stated the licensee was aware annual performance reviews were required, however, ULP-F's employee record did not include annual performance reviews since ULP-F only worked minimal hours. ULP-K ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility.	0 650			

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0 650	Continued From page 9 On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-K's employee record lacked a job description. On April 8, 2026, at 12:27 p.m., LALD-A stated the licensee provided employee job descriptions upon hire, however, ULP-K's employee record lacked a job description. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person will include a current signed job description and documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660			

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0 660	Continued From page 10 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-K). 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 April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on December 26, 2025, and the facility was determined to be a low risk level.	0 660			

Minnesota Department of Health

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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
0 660	Continued From page 11 ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-K's employee record contained a negative TB screen and first step TST administered on September 10, 2025, however, lacked the reading results of the first TST. ULP-K's employee record lacked a second step TST. On April 8, 2026, at 12:25 p.m., clinical nurse supervisor (CNS)-C stated ULP-K's employee record lacked results from the first TST administration and lacked a second step TST. CNS-C further stated the licensee had recently changed the process for TB screening, which included new staff to complete a TB screening on site and then complete a blood draw at the local clinic to test for TB. The licensee's TB Infection Control and Prevention Policy and Procedure policy dated December 6, 2021, indicated paid or unpaid employees will have a 2 (two)-step Mantoux (TST) or single interferon gamma release assay (IGRA) blood test, the results of the method used will be documented on the Baseline TB Screening Tool for HCWs (health care workers). The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes	0 660			

Minnesota Department of Health

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0 660	Continued From page 12 assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

Minnesota Department of Health

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0 680	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. LALD-A stated LALD-A was responsible for developing and maintaining the licensee's EPP. The licensee's EPP dated September October 31,2025, did not include the development of following policies and procedures to include: - a quarterly review of the missing resident policy; - a description of population served by the licensee; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, and emergency lighting); - an Emergency Prep Testing Requirements that must include the following:	0 680			

Minnesota Department of Health

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0 680	Continued From page 14 - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On April 8, 2026, at 2:02 p.m., the surveyor and LALD-A reviewed the licensee's EPP and LALD-A confirmed the EPP was missing the required content noted above. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775			

Minnesota Department of Health

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0 775	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810			

Minnesota Department of Health

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0 810	Continued From page 16 (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, 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 17 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 April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) 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; (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	01060			

Minnesota Department of Health

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01060	Continued From page 18 (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 observation, interview, and record review, the licensee 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 (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)	01060			

Minnesota Department of Health

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01060	Continued From page 19 The findings include: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with the current assisted living laws and regulations. The licensee's Current Resident Roster dated April 6, 2026, identified that R2 had a hospitalization. R2's diagnoses included diabetes, atrial flutter, asthma, vascular disease, depressive disorder, post traumatic stress disorder (PTSD), traumatic brain injury (TBI), and panic disorder. On April 7, 2026, at 6:39 a.m., the surveyor observed unlicensed personnel (ULP)-K administering R2's medications. R2's Resident Notes indicated the following: -On December 27, 2025, R2 continued to be in the emergency room for escalation in behaviors. -On January 12, 2026, [name of the care provider] provided an update indicating, R2 started on a new medication and was working on getting R2 a wheelchair prior to R2's discharge back to the facility. -On January 28, 2026, R2 was scheduled for a discharge from the geriatric unit on January 29, 2026, for a planned pickup time of 9:00 a.m., January 29, 2026, by the facility. R2's record included a written notice that was provided to the resident or the resident's representative at the time of R2's emergency relocation; however, R2's record lack documentation the ombudsman was notified of	01060			

Minnesota Department of Health

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01060	Continued From page 20 R2's hospitalization of four days or longer. On April 7, 2026, at 2:16 p.m., O-B stated O-B was responsible for sending relocation notices to the ombudsman; however, was unable to find documentation in R2's record O-B notified the ombudsman of R2's hospitalizations. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, 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; The notice required will be delivered as soon as practicable to: -the resident, legal representative, and designated representative; -for residents who receive home and community-based waiver services, the resident's case manager; and -the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060			

Minnesota Department of Health

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01060	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=I	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 observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of three employees (unlicensed personnel (ULP)-)E. In addition, the licensee failed to affiliate an employee background study with the licensee's health care facility identification (HFID) number for one of three employees (ULP)-F. This had the potential to affect all residents living within the facility.	01290			

Minnesota Department of Health

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01290	Continued From page 22 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: This resulted in an immediate correction order on April 7, 2026. During the entrance conference on April 6, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. NO BACKGROUND STUDY ULP-E ULP-E was hired on December 17, 2025, to provide direct care services to residents. On July 7, 2026, at 7:01 a.m., the surveyor observed the daily staff schedule written on the white board dated Tuesday, April 7, 2026, listed ULP-E scheduled to work 2:00 p.m., to 10:00 p.m. The licensee's weekly staff schedule dated April 6, 2026, through April 12, 2026, indicated ULP-E was scheduled to work April 7, 8, 9, and 10, from 2:00 p.m., to 10:00 p.m. ULP-E's employee record lacked a cleared background study for the licensee.	01290			

Minnesota Department of Health

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01290	Continued From page 23 BACKGROUND STUDY AFFILIATION ULP-F ULP-F was hired July 23, 2020, to provide direct care services to the residents. ULP-F's employee record contained a Department of Human Services (DHS) background study clearance letter dated July 15, 2020, with the licensee's previous comprehensive license HFID 26859; however, ULP-F's record lacked a cleared background study with the licensee's current HFID 23725. On April 6, 2026, at 2:50 p.m., the surveyor reviewed the employee roster with O-B and confirmed ULP-E and ULP-F were current employees of the license and provided direct care services to the residents. The surveyor reviewed the licensee's NETStudy 2.0 Roster with O-B and O-B verified ULP-E and ULP-F were not listed on the licensee's NETStudy 2.0 Roster. O-B stated LALD-A was responsible for employee background studies and LALD-A would be able to provide additional information. On April 7, 2026, at approximately 9:00 a.m., LALD-A stated ULP-F had been hired under the licensee's previous comprehensive license which had been closed and had not obtained a background study with the licensee's current HFID 23725. LALD-A stated ULP-E did not have a background study for the licensee. LALD-A stated LALD-A had been having difficulty in completing the process for ULP-E's background study and submitted the application and paid the fees on three separate occasions; however, for some reason have been unable to complete the	01290			

Minnesota Department of Health

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01290	Continued From page 24 process. On April 7, at 12:22 p.m., O-B stated ULP-E and ULP-F worked for the licensee in the past two weeks and both were scheduled to work today. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at the licensee. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The licensee would not employ individuals whose results of the background study indicate disqualification for the position. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 25 supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01370	Continued From page 26 (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed for two of two unlicensed personnel ((ULP)-H, ULP-K) to include all required content. 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 April 6, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-H ULP-H was hired on June 30, 2022, and effective	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01370	Continued From page 27 September 12, 2025, began to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 7:38 a.m., the surveyor observed ULP-H administering R6's scheduled morning medications. ULP-K ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-H and ULP-K's employee records lacked sufficient evidence of training by the registered nurse (RN) for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. On April 8, 2026, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated the licensee was in the process of training in new RNs regarding the hiring process for ULPs. CNS-C further stated the RN was supposed to assign the above noted topics via Educare (online training platform)	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01370	Continued From page 28 during ULPs on-boarding process, however, the above noted topics were not assigned to any recent ULPs as part of the orientation process. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a RN or licensed health professional staff of (licensee name) delegates tasks, prior to the delegation of services they (RN or licensed health professional) must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client (resident). The policy addressed all training topics noted above. In addition, a copy of all education, training, and competency testing shall be kept in each employee's personnel file. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01370	Continued From page 29 (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed for two of two unlicensed personnel ((ULP)-H, ULP-K) to include all required content.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01380	Continued From page 30 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 April 6, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-H ULP-H was hired on June 30, 2022, and effective September 12, 2025, began to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 7:38 a.m., the surveyor observed ULP-H administering R6's scheduled morning medications. ULP-K ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-H and ULP-K's employee records lacked documentation of training by the registered nurse (RN) for the following topics:	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01380	Continued From page 31 - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On April 8, 2026, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated the licensee was in the process of training in new RNs regarding the hiring process for ULPs. CNS-C further stated the RN was supposed to assign the above noted topics via Educare (online training platform) during ULPs on-boarding process, however, the above noted topics were not assigned to any recent ULPs as part of the orientation process. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a RN or licensed health professional staff of (licensee name) delegates tasks, prior to the delegation of services they (RN or licensed health professional) must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client (resident). The policy addressed all training topics noted above. In addition, a copy of all education, training, and competency testing shall be kept in each employee's personnel file. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic:	01380			

Minnesota Department of Health

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01380	Continued From page 32 (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470			

Minnesota Department of Health

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01470	Continued From page 33 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01470	Continued From page 34 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of three employees (unlicensed personnel (ULP)-H, ULP-K). 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: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-H ULP-H was hired on June 30, 2022, and effective September 12, 2025, began to provide direct care services to residents at the assisted living with dementia care facility.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01470	Continued From page 35 On April 7, 2026, at 7:38 a.m., the surveyor observed ULP-H administering R6's scheduled morning medications. ULP-H's employee record contained Transcripts dated January 27, 2026, however, ULP-H's employee records lacked the following required orientation topics: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Managed Care Ombudsman at the Department of Human Services (DHS), county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-K ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-K's employee record contained Transcripts dated April 6, 2026, however, ULP-K's employee	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01470	Continued From page 36 records lacked the following required orientation topics: -an overview of chapter 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the OOLTC, OOMHDD, Managed Care Ombudsman at DHS, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On April 8, 2026, at 12:08 p.m., LALD-A stated the licensee used Educare (online training platform) to assign orientation to assisted living topics for new employees. LALD-A further stated LALD-A was not sure why ULP-H and ULP-K did not complete all required courses to complete orientation to assisted living. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated June 12, 2025, indicated all (licensee name) employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -an overview of the appropriate Assisted Living [sic] statues and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01470	Continued From page 37 -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the OOLTC, OOMHDD, Managed Care Ombudsman at DHS, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01500	Continued From page 38 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01500	Continued From page 39 received all the required content for annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-F was hired on July 23, 2020, and effective August 1, 2021, began to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 3:00 p.m., the surveyor observed ULP-F shave R3 with an electric razor. ULP-F's employee record lacked the following required annual training topics: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01500	Continued From page 40 disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 8, 2026, at 12:17 p.m., LALD-A stated the licensee had assigned the above noted annual training topics on Educare (online training platform) to ULP-F, however, ULP-F had not completed the courses. LALD-A further stated the licensee was aware of all required topic content for annual training. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services at (licensee name) will complete at least eight (8) hours of annual training for each 12 months of employment. In addition, the policy included required annual training for the above noted topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01540 SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01540	Continued From page 41 is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-F, ULP-K) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01540	Continued From page 42 The licensee held an assisted living facility with dementia care (ALFDC) license issued on April 1, 2026, though March 31, 2027. During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. ULP-F ULP-F was hired on July 23, 2020, and effective August 1, 2021, began to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 3:00 p.m., the surveyor observed ULP-F shave R3 with an electric razor. ULP-F's Transcripts dated April 6, 2026, indicated ULP-F had completed 0.75 hours of mental illness training. ULP-F's employee record lacked ULP-F had completed two hours of initial training on mental illness and de-escalation by July 1, 2025. ULP-K ULP-K was hired on July 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On April 7, 2026, at 6:39 a.m., the surveyor observed ULP-K administering R2's scheduled morning medications. ULP-K's employee record lacked evidence ULP-K had completed two hours of mental illness and de-escalation training within 80 working hours of	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01540	Continued From page 43 ULP-K's employment start date. On April 8, 2026, at 12:20 p.m., LALD-A stated ULP-F was assigned to complete two hours of mental illness and de-escalation training on Educare (online training platform), however, ULP-F did not complete the assigned courses. LALD-A further stated ULP-K had worked over 80 hours for the licensee and was not sure why ULP-K did not complete two hours of mental illness and de-escalation training. LALD-A stated the licensee assigned two hours of initial mental illness and de-escalation upon employment hire and two hours to active employees who were supposed to complete the courses prior to July 1, 2025. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated June 12, 2025, all direct care staff and supervisors providing direct services must also demonstrate an understanding of required related dementia, mental illness, and de-escalation [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8),	01550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01550	Continued From page 44 within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (cook (C)-J) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was aware of required contents in an employee record. C-J was hired on January 4, 2022, to cook meals for residents at the assisted living with dementia care facility. During the course of the survey, C-J was	01550			

Minnesota Department of Health

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01550	Continued From page 45 observed preparing and serving resident meals. C-J's employee record lacked evidence of two hours of initial training on mental illness and de-escalation, and two hours of annual training on dementia for the years of 2023, 2024, and 2025, respectively. On April 8, 2026, at 12:21 p.m., LALD-A stated C-J was assigned to complete two hours of mental illness and de-escalation training along with two hours of annual dementia training on Educare (online training platform), however, C-J had not completed the courses assigned to C-J. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all staff will complete two (2) hours of additional dementia training for each 12 months of work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640			

Minnesota Department of Health

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01640	Continued From page 46 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect current services provided for two of two residents (R2, R3) and authenticated 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 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: During the entrance conference on March 6, 2026, at 10 51: a.m., licensed assisted living director (LALD)-A and owner(O)-B stated the licensee was familiar with current minimum assisted living requirements. O-B stated resident service plans were completed by the registered nurse and updated with changes in resident	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01640	Continued From page 47 services, signature was obtained by the resident or resident's representative and copy of the services plan was offered. R2 R2's diagnoses included atrial fibrillation, pulmonary edema, vascular disease, diabetes, dyspnea (shortness of breath), traumatic brain injury (TBI), schizophrenia, and asthma. On April 7, 2026, at 8:37 a.m., the surveyor observed unlicensed personnel (ULP)-H obtain R2's blood glucose with reading of 84 millimeters per deciliter (mm/dl). R2's Individualized Treatment and Therapy Plan dated April 7, 2026, indicated blood glucose monitoring four times a day effective July 6, 2023, and daily weight effective April 3, 2026. R2's Service Plan (Waiver)-Addendum to Contract effective date, February 28, 2026, included medication management, blood glucose monitoring, grooming, bathing, dressing, incontinence care, toileting, oxygen saturation monitoring, daily pulse and weight, behavior management, activities, housekeeping, and laundry; however, R2's service plan lacked authentication by the licensee and the resident and or resident's representative agreement on the services to be provided. R2's April 2026 Service Recap Summary, indicated R2 was scheduled and received the following services noted above. R2's Resident Notes dated November 7, 2025, through April 7, 2026, did not indicate R2 or R2's representative was informed and agreed to changes in R2's service plan or attempts the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01640	Continued From page 48 licensee took to obtain R2's guardian's signature. R3 R3's diagnoses included diabetes type II, hypertension (high blood pressure), and dementia. R3's Service Plan (Private)-Addendum to Contract dated February 20, 2026, indicated R3 received assistance with medication administration, Dexcom (blood glucose monitoring) sensor changing every 10 days, dressing, grooming, bathing, toileting, bed mobility, ambulation, transferring, meal assist, skin cares, housekeeping and laundry. R3's Individualized Treatment and Therapy Plan printed April 8, 2026, did not indicate R3 received blood glucose monitoring. R3's Service Delivered dated April 2026, indicated R3 was scheduled and received behavior monitoring and safety checks three times a day, which were not included on R3's service plan. In addition, R3's Dexcom sensor changes were not listed on R3's March and April 2026, as a service to be provided. R3's Resident Notes dated February 27, 2026, indicated R3's Dexcom was discontinued and the Dexcom sensor had been removed. R3's Resident Notes dated December 1, 2025, through April 8, 2026, did not indicate R3 or R3's representative was informed and agreed to changes in R3's service plan or attempts the licensee took to obtain R3's representative's signature. On April 8, 2026, at 2:30 p.m., clinical nurse	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01640	Continued From page 49 supervisor (CNS)-C stated R2's updated service plan had a sticky note attached that indicated "waiting for guardian signature". CNS-C stated CNS-C was unable to find documentation in R2's record R2's guardian was informed of changes to R2's service plan or attempts the licensee took to obtain a R2's signature. CNS-C stated R3's family came in yesterday (April 7, 2026), and signed a new updated service plan. CNS-C stated R3's service plan had not been updated or signed prior to the start of the survey. The licensee's Service Plan Modifications dated August 1, 2021, indicated when a resident receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01640			
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 for one of one medication refrigerator.	01880			

Minnesota Department of Health

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01880	Continued From page 50 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee provided medication storage for the residents at the facility. On April 6, 2026, at 1:53 p.m., the surveyor reviewed the medication refrigerator with unlicensed personnel (ULP)-G and observed the internal thermometer temperature reading of 44 degrees Fahrenheit (F). ULP-G stated staff monitored the refrigerator temperatures daily and record results on a paper temperature log. The licensee's Med Fridge Temperature Verification log indicated temperatures must be between 36 to 46 degrees F and to contact LALD-A if out of range. The following recorded temperatures were documented below 36 degrees F: -February 1 through 28, 2026, indicated five out of 28 recorded temperatures were out of range; and -March 1 through March 31, 2026, indicated five out of 31 temperatures were recorded out of range.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01880	Continued From page 51 On April 8, 2026, at 3:10 p.m., the surveyor reviewed the contents of the medication refrigerator with ULP-H and observed the following medications being stored by the licensee: -three unopened Tresiba (long-acting) prefilled insulin pens; -nine unopened Fiasp (fast-acting) insulin pens; -one unopened Lantus (long-acting) vial of insulin; -six unopened Basaglar (long-acting) prefilled insulin pens; -two unopened Zegalogue (used to treat low blood glucose) prefilled injection pens; -one 10 milligrams (mg)/ 50 milliliters (ml) bottle of liquid Raldesy (used to treat major depressive disorders); -one unopened Lantus prefilled insulin pens; -four unopened Novolog (rapid-acting) prefilled insulin pens; and -one bottle of liquid gabapentin (used to treat nerve pain/seizures). ULP-H stated if the medication refrigerator temperatures were out of range, staff should notify nursing or management. The manufacturer's instructions for Tresiba insulin dated July 2022, indicated to store unopened Tresiba in the refrigerator at 36 to 46 degrees F and do not use if it has been frozen. The manufacturer's instructions for Fiasp insulin dated October 2019, to store unused insulin in the refrigerator at 36 to 46 degrees F and do not use if it has been frozen The manufacturer instructions for Lantus insulin dated June 2022, indicated to store unopened Lantus insulin in the refrigerator between 36 F to 46 F. Do not allow Lantus to freeze.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
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01880	Continued From page 52 The manufacturer's instructions for Basaglar insulin dated 2022, indicated to store unused insulin pens in the refrigerator at 36 to 46 degrees F and do not use if it has been frozen. The manufacturer's instruction for Zegalogue dated January 2023, in the refrigerator between 36 to 46 degrees F and do not freeze. The manufacturer's instructions for Raldesy (trazadone) dated November 2024, indicated to store at room temperature between 68 to 77 degrees F. The manufacturer instructions for Novolog insulin February 2023, indicated store unopened Novolog in the refrigerator between 36 F to 46 F. Do not allow Novolog to freeze. The manufacturer's instructions for liquid gabapentin (Neurontin) dated July 2010, to store in the refrigerator between 36 to 46 degrees F. On April 8, 2026, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated staff should be monitoring and recording the medication refrigerator temperatures daily and reporting if temperatures were out of range. CNS-B stated CNS-B was unaware refrigerator temperatures had been out of range on several occasions and there was no documentation staff had reported out of range temps or action taken. The licensee's Medication and Storage policy dated August 1, 2021, indicated medications managed by the licensee would be kept securely locked and stored per manufacturer directions. No further information was provided.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER AUTUMN LANE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 36858 PINCHERRY ROAD COHASSET, MN 55721		
(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
01880	Continued From page 53	01880			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. 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).	02040			

Minnesota Department of Health

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02040	Continued From page 54 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	02040			
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) 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. Only a 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. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.	02410			

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02410	Continued From page 55 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents (R2, R3) privacy was maintained during the use of electronic monitoring devices. 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: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. During the facility tour with O-B on April 6, 2026, at 12:10 p.m., the surveyor observed two small video monitor devices sitting on a buffet table in the main living area for the facility. The video screens were live recordings of resident rooms which could be observed from the main living area of the facility. On April 6, 2026, at 12:47 a.m., unlicensed personnel (ULP)-G identified R3 and R4 had live video cameras in their room due to resident falls. ULP-G stated the cameras were kept on 24/7. R3 R3's diagnoses included cerebral atherosclerosis	02410			

Minnesota Department of Health

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02410	Continued From page 56 (plaque buildup in the brain arteries), adult failure to thrive, diabetes, dementia, psychotic disorder, mood disorder and anxiety. R3's Service Plan (Waiver)- Addendum to Contract dated February 20, 2026, indicated R3's services included medication administration, dressing, grooming, toileting, bathing, skin cares, ambulation, transferring, housekeeping and laundry. R3's Clinical Update Assessment dated March 5, 2026, indicated R3 had history of confusion at bedtime, was a risk for falls, had occasional incontinence of bowel and bladder, and required assistance with dressing, grooming, bathing, toileting and transferring. R3's assessment indicated R3 did not have an electronic monitoring device in use. R4 R4's diagnoses included atrial fibrillation (irregular increased heart rate), anxiety and congested heart failure. R4's Service Plan (Waiver)- Addendum to Contract service dated January 21, 2026, indicated R4 received services to include medication administration, assistance with dressing, grooming, bathing, toileting, vital signs monitoring twice a day, meal assistance, housekeeping and laundry. R4's 90-Day Assessment dated January 21, 2026, indicated R4 had a problem with memory, a history of verbal and aggressive behaviors, was at risk for falls, had occasional incontinence of bladder, and required assistance with medication administration, eating assistance, bathing, grooming, dressing, housekeeping and laundry.	02410			

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02410	Continued From page 57 R3's assessment indicated R3 did not have an electronic monitoring device in use. R4's 90-Day Assessment dated April 6, 2026, indicated an electronic monitoring device was added to R4's assessment after survey start date and surveyor requested R4's records for review. On April 7, 2026, at 6:45 a.m., the surveyor observed two video monitor devices sitting on a buffet table in the main sitting/dining area in the facility. The screens of the video monitors were facing towards the open areas of the dining room, sitting room and main pathway of the facility and could be visualized by any staff, residents and visitors in the area. Both monitors were turned on and showed active video footage of the resident's room. R4 was observed lying in bed in his room from the video screen monitor. The other video monitor screen viewed R3's room and R3 was not observed to be in the room. On April 7, 2026, at 10:20 a.m., LALD-A stated the electronic monitoring devices were recently placed in R3 and R4's room due to falls. LALD-A stated the monitor screens were kept in the main living area to allow staff to view residents while R3 and R4 were in their rooms. LALD-A did not consider R3 and R4's privacy as the monitor screens could be visualized by any staff, visitor, or residents in the area. On April 8, 2026, at 9:24 a.m., the surveyor observed from the video monitor screen, R3 in bed and ULP-H was in R3's room getting room prepared to get R3 up for the day. On April 8, 2026, at 10:30 a.m., the surveyor observed from the video monitor screen located in the main living area R4 was in his room sitting in a recliner chair.	02410			

Minnesota Department of Health

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02410	Continued From page 58 The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the licensee would support the use of electronic monitoring devices by residents and resident representatives (as defined in the law). The licensee would require resident consents outlined in 144.66502. The consent must be provided on the form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			
03070 SS=F	144.6502, Subd. 6 Form Requirements (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain consent for electronic monitoring for two of two residents (R3, R4) who had an electronic monitor device in place. 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	03070			

Minnesota Department of Health

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03070	Continued From page 59 of the residents). The findings include: During the entrance conference on April 6, 2026, at 10:51 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the licensee was familiar with current minimum assisted living requirements. During the facility tour with O-B on April 6, 2026, at 12:10 p.m., the surveyor observed two small video monitor devices sitting on a buffet table in the main living area for the facility. The video screens were live recordings of resident rooms which could be observed from the main living area of the facility. On April 6, 2026, at 12:47 a.m., unlicensed personnel (ULP)-G identified R3 and R4 having live video cameras in their room due to falls. R3 R3's diagnoses included cerebral atherosclerosis (plaque buildup in the brain arteries), adult failure to thrive, diabetes, dementia, psychotic disorder, mood disorder and anxiety. R3's Service Plan (Waiver)- Addendum to Contract dated February 20, 2026, indicated R3's services included medication administration, dressing, grooming, toileting, bathing, skin cares, ambulation, transferring, housekeeping and laundry. R3's Clinical Update Assessment dated March 5, 2026, indicated R3 had history of confusion at bedtime, was a risk for falls, had occasional incontinence of bowel and bladder, and required assistance with dressing, grooming, bathing,	03070			

Minnesota Department of Health

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03070	Continued From page 60 toileting and transferring. R3's assessment indicated R3 did not have an electronic monitoring device in use. R4 R4's diagnoses included atrial fibrillation (irregular increased heart rate), anxiety and congested heart failure. R4's Service Plan (Waiver)- Addendum to Contract service dated January 21, 2026, indicated R4 received services to include medication administration, assistance with dressing, grooming, bathing, toileting, vital signs monitoring twice a day, meal assistance, housekeeping and laundry. R4's 90-Day Assessment dated January 21, 2026, indicated R4 had a problem with memory, a history of verbal and aggressive behaviors, was at risk for falls, had occasional incontinence of bladder, and required assistance with medication administration, eating assistance, bathing, grooming, dressing, housekeeping and laundry. R3's assessment indicated R3 did not have an electronic monitoring device in use. R4's 90-Day Assessment dated April 6, 2026, indicated an electronic monitoring device was added to R4's assessment after survey start date and surveyor requested R4's records for review. R3 and R4's records lacked written consent for the electronic monitoring devices placed in R3 and R4's rooms. On April 7, 2026, at 6:45 a.m., the surveyor observed two video monitor devices sitting on a buffet table in the main sitting/dining area in the facility. The screens of the video monitors were facing towards the open areas of the dining room,	03070			

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03070	Continued From page 61 sitting room and main pathway of the facility and could be visualized by any staff, residents and visitors in the area. Both monitors were turned on and showed active video footage of the resident's room. R4 was observed lying in bed in his room from the video screen monitor. The other video monitor screen viewed R3's room and R3 was not observed to be in the room. On April 7, 2026, at 10:20 a.m., LALD-A stated the electronic monitoring devices were recently placed in R3 and R4's room due to falls. LALD-A stated the monitors were kept in a main living area to allow staff to view residents while R3 and R4 were in their rooms. On April 8, 2026, at 11:04 a.m., CNS-C stated CNS-C completed R4's assessment yesterday (April 7, 2026) and added electronic monitoring to R4's assessment and was waiting for the family to sign a consent for R4's electronic monitoring. CNS-C provided a signed consent for R3's electronic monitoring dated March 30, 2026; however, CNS-C stated R3's representative signed the consent after March 30, 2026, and the date was backdated to indicate the date the monitoring device was set up in R3's room and was not actually signed on March 30, 2026. CNS-C stated R3 and R4's records did not include documentation of consent for use, initiation of the electronic monitoring devices or signed consents prior to surveyor's request of documentation or start of the survey. On April 8, 2026, at 9:24 a.m., the surveyor observed from the video monitor screen, R3 in bed and ULP-H was in R3's room getting room prepared to get R3 up for the day. On April 8, 2026, at 10:30 a.m., the surveyor	03070			

Minnesota Department of Health

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03070	Continued From page 62 observed from the video monitor screen located in the main living area R4 was in his room sitting in a recliner chair. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the licensee would support the use of electronic monitoring devices by residents and resident representatives (as defined in the law). The licensee would require resident consents outlined in 144.66502. The consent must be provided on the form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03070			



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Autumn Lane Inc
36858 PINCHERRY ROAD
Cohasset, MN 55721
Itasca County
Parcel:
Phone:

License Info

License: HFID 23725
David Brenden
Risk: N/A
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7939261090
Inspection Type: Full - Single
Date: 4/6/2026 Time: 11AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: DAVID HAS NOT APPLIED WITH THE STATE OF MN. DISCUSSED WEB PAGE WITH DAVID.

Comply By: 4/6/2026 Originally Issued On: 4/6/2026

! New Order: 5-400 Sewage

5-403.11 Priority Level: Priority 1 CFP#: 52

MN Rule 4626.1215 Dispose of sewage through an approved public sewage treatment plant or an individual sewage disposal system that is sized, constructed, maintained and operated according to Minnesota Pollution Control Agency Rules Chapters 7080 and 7081.

COMMENT: SEPTIC SYSTEM HAS A POSSIBLE LEAK AND MUST BE INSPECTED AND CORRECTED BY AN APPROVED CONTRACTOR.

Comply By: 4/6/2026 Originally Issued On: 4/6/2026

Food & Beverage General Comment

DISCUSSION

CFPM APPLICATION

SEPTIC ISSUES

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 Bemidji District Office inspection report number F7939261090 from 4/6/2026

DAVID BRENDEN
OWNER


Ryan Trenberth,
Public Health Sanitarian 3
218-308-2133
ryan.trenberth@state.mn.us



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

Autumn Lane Inc
Cohasset
County/Group: Itasca County

Inspection Info

Report Number: F7939261090
Inspection Type: Full
Date: 4/6/2026
Time: 11AM

Food Temperature: **Product/Item/Unit:** Cottage cheese; **Temperature Process:** Cold-Holding

Location: Kitchen at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Beef base; **Temperature Process:** Cold-Holding

Location: Dry Storage cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sausage; **Temperature Process:** Cooking

Location: Oven at 190 Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Inspection Info

Autumn Lane Inc
Cohasset
County/Group: Itasca County

Report Number: F7939261090
Inspection Type: Full
Date: 4/6/2026
Time: 11AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL23725016	Date: 4/7/2026
Facility Name: Autumn Lane Inc.	
Facility Address: 36858 Pincherry Rd. Cohasset Mn 55721	

☒ TAG IDENTIFICATION: 0775	
SCOPE/ SEVERITY: Level 2; Widespread	TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Controlled egress doors shall: unlock upon activation of either the automatic sprinkler system or smoke detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked by a signal or switch from the fire command center, nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: The emergency exit doors had a keypad that required a code to unlock the doors. When interviewed about the controlled egress locking system, director of facilities (DOF)-E stated that there was no manual override for the controlled egress locks in the memory care unit.

3. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]
- Comments: One of the emergency exit doors that exited onto a deck had a lock that required a key to unlock the gate. When interviewed about the controlled egress locking system, Licensed assisted living director (LALD)-A stated that there was no manual override for the controlled egress locks. This same gate does not unlock when the fire alarm system is activated.*

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

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

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

Comments: The licensed assisted living director (LALD)-A was unable to provide a fire safety evacuation plan that had details for resident-specific movement, evacuation or relocation and did not include the identification of unique or unusual resident needs for movement or evacuation.

3. Residents who are capable of assisting in their own evacuation shall be trained in 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-A stated that the residents did receive training on the steps to take in the event of an evacuation, but they did not provide any documentation.

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 documentation that was provided did not have any evacuation drills done in 2026. The fire drill logs for 2025 showed drills done September, October, November, and December. LALD-A stated that the fire drills were not being done in a timely manner, and he understood that they were not meeting the requirements of every other month.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: A review of the safety risk assessment showed environmental risks for the physical environment, but it did not address the mitigation steps for these risks. LALD-A stated he was not aware that they needed to include the mitigation process.