Electronically Delivered

March 26, 2026

Licensee
Golden Horizons
1790 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL30345016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 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 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	1790 COLLEGEWAY WORTHINGTON, MN 56187

(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: SL30345016-0 On March 2, 2026, through March 6, 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 35 residents; 35 receiving services under the Assisted Living Facility with Dementia Care license. 1620: An immediate correction order was issued on March 5, 2026, at a level 4/Isolated (J). The licensee took immediate action; however, the scope and level remains at J.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-N was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 2, 2026, at 10:09 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website identified LALD-N was director of record which ended January 1, 2026. During the entrance conference on March 2, 2026, at 1:46 p.m., operations director/registered nurse (OD/RN)-G stated LALD-N was the LALD for the facility. On March 9, 2026, at 8:02 a.m., a BELTSS representative indicated LALD-N edited her	0 110		

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0 110	Continued From page 2 Director of Record on March 2, 2026, the day survey began. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to schedule staff based on their staffing plan and failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review. This had the potential to affect all 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, 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: The licensee's census was 35 residents, all of whom received services under the assisted living license. During the facility tour on March 2, 2026, at 9:48 a.m. with clinical nurse supervisor (CNS)-A, no posting for staffing was observed. CNS-A stated she was not aware of a staff posting and had not seen one posted. On March 2, 2026, at 1:15 p.m. human resources coordinator (HRC)-F stated there was not a staff posting and she was going to post it. On March 2, 2026, during the entrance conference at 1:46 p.m., operations director/registered nurse (OD/RN)-G stated the evening shift was 3:00 p.m.-11:00 p.m. There were four staff working during that time, two	0 470		

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0 470	Continued From page 4 scheduled 3:00 p.m.-11:00 p.m. and two staff worked 4:00 p.m.-9:00 p.m. The licensee's Staffing Plan dated December 1, 2025, indicated the evening shift was scheduled to have four staff working, two staff were scheduled 3:00 p.m.-11:00 p.m. and two staff were scheduled 4:00 p.m.-9:00 p.m. The licensee's staff schedule dated March 1, 2026, through March 7, 2026, indicated the evening shift had two staff scheduled 3:00 p.m..-11:00 p.m. On March 4, 2026, at 1:44 p.m., operations director/registered nurse (OD/RN)-G stated the actual staffing should have matched the staffing plan. The shorter shifts were supposed to be temporary. OD/RN-G stated the staffing plan should have been updated when the staffing changed, and the facility should be staffed according to the staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 485 SS=F	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and	0 485		

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0 485	Continued From page 5 made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a menu prepared at least one week in advance provided to the residents as required. This had the potential to affect all residents who received services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 2, 2026, at 12:25 p.m., the surveyor did not observe a menu posted in the assisted living area or in the memory care area. On March 2, 2026, at 1:05 p.m., cook (C)-J stated they did not have a menu that they followed. C-J stated due to staff separating employment the week before, there was no food order placed;	0 485		

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0 485	Continued From page 6 therefore, staff were utilizing local grocery stores to buy the food and they were "winging" it to prepare meals. C-J further stated they had catered in meals over the weekend for the residents. On March 3, 2024, at 12:40 p.m., registered nurse (RN)-H stated the kitchen staff should have had a menu to follow and would try to find one for them. The licensee's Dietary Services policy dated November 3, 2025, included: 2) [Licensee name] Menus are prepared a week in advance and made available to residents at that time. 3) [Licensee name] partners with a food services company to ship and deliver foods, beverages, chemicals, and supplies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for	0 490		

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0 490	Continued From page 7 providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide reasonable assistance with a daily program of social and recreational activities based on individual interests and mental and psychosocial needs for the facility's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 2, 2026, during the entrance conference at 1:46 p.m., operations director/registered nurse (OD/RN)-G stated they	0 490		

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0 490	Continued From page 8 provide a daily program of social and recreational activity and culturally sensitive programs. During the survey March 2, 2026, through March 5, 2026, the surveyor did not observe any activities occurring in the assisted living or in the memory care. On March 2, 2026, at 4:15 p.m., the surveyor observed six residents wandering up and down the hallways and one resident sitting in a reclining wheelchair in the dining room. ULP-I was observed in the memory care area exiting a resident room. ULP-I stated she typically worked evenings and there were no activities occurring on the evening shift, they only occurred during the day. On March 3, 2026, at 8:30 a.m., ULP-D stated since there was currently no activity staff employed right now, so they tried to do something with the residents depending on how busy they were. Some of the activities included turning on the television to a movie, balloon ball, nails, and sometimes they would bring residents to the assisted living side to listen to music. On March 3, 2026, at 12:40 p.m., registered nurse (RN)-H stated the activity staff separated employment the week before and they could not find an activity calendar. The unlicensed personnel should be doing activities with the residents in the interim. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		

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0 510	Continued From page 9	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 2, 2026, at 11:21 a.m., the surveyor observed ULP-B administering eye drops to R6. ULP-B asked R6 to lay back in his chair, ULP-B	0 510		

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0 510	Continued From page 10 then assisted to hold the bottom eyelid open and put the drops in the eye. ULP-B did not wear gloves during the procedure. On March 3, 2026, at 11:11 a.m., operations director/registered nurse (OD/RN)-G stated Staff should have been wearing gloves when administering the eye drops. The licensee's Medications, Treatment and Therapy Administration by Unlicensed Personnel policy dated January 1, 2026, indicated infection control practices would be followed when administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

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0 680	Continued From page 11 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. This had the potential to affect all 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). The findings include: The licensee's emergency preparedness binder included the following policies all dated January 1, 2025: - Disaster Planning and Emergency Preparedness Plan; - Disaster; - Fire; - Emergency/911; - Infection Control; - Bomb and Bomb Threats;	0 680		

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0 680	Continued From page 12 - Bill of Rights; and - Billing policy. The emergency preparedness binder lacked the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - facility risk assessment; - arrangements/contracts to re-establish utility services; - all hazards approach with categorized probable risks/hazards by likelihood of occurrence; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - identification of at-risk population needs like maintaining independence, communication, transportation, supervision and medical care; - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program; - policies and procedures based on the EPP, risk assessment and communication plan; - policy and procedure to address medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility;	0 680		

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0 680	Continued From page 13 - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EPP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EPP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff,	0 680		

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0 680	Continued From page 14 individuals providing services under arrangement, and volunteers consistent with their expected roles. - documentation of all EPP training; and - emergency prep testing requirements. - Missing Resident Policy, failed to be reviewed quarterly as required. The licensee provided a second facility binder, Fire Safety and Evacuation Plan dated January 1, 2026, which included additional policies related to fire and evacuation. On March 6, 2026, at 1:54 p.m., the licensee's emergency preparedness plan was reviewed with Operations director/ registered nurse (OD/RN)-G. OD/RN stated the above noted content was not in the emergency preparedness plan No additional 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: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 775		

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0 775	Continued From page 15 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 3/5/2026, 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; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 16 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 17 Environment Inspection Report (PEIR) dated 3/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01620 SS=J	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

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01620	Continued From page 18 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to timely assess and implement interventions after falls for one of one resident (R4), resulting in actual harm. This resulted in an immediate correction order identified on March 5, 2026. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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:	01620		

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01620	Continued From page 19 On March 2, 2026, at 4:15 p.m., unlicensed staff (ULP)-I exited R4's room pushing her in a reclining wheelchair. The surveyor observed purple and green faded bruising on R4's face and neck and a bandage to R4's right temple. On March 3, 2026, at 9:25 a.m., ULP-C stated R4 has had multiple falls the last couple weeks. A previous fall, R4 had sustained a "gash" to the back of the head and returned to the facility with hospice services. Prior to that fall, R4 had been ambulatory and walked around the memory care independently, and staff could understand her speech. After R4 returned from that fall, she was no longer walking and staff could not understand her. ULP-C stated they would try to ambulate with her, but it is hard and she leans to the right. ULP-C stated R4 has had multiple falls since then, but ULP-C was unsure of the details as they did not occur on her shift. R4 was admitted and began receiving services on December 7, 2024, and resided in the memory care unit of the facility. R4's diagnoses included Alzheimer's dementia with behavioral disturbance. R4's service plan dated February 3, 2026, indicated R4's services included behavior management for wandering and exit seeking behaviors, anxiety, and redirection, safety checks five times per day, toileting assist 10 times a day, dressing, grooming, bathing, TED (thrombo embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling), and medication administration. R4's medical record included the following:	01620		

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01620	Continued From page 20 - December 1, 2025, at 5:24 a.m. R4 was found on her floor with an injury to the right eye. Unlicensed staff called 911, R4 was transported to the hospital and was admitted. - December 1, 2025, at 4:24 p.m. registered nurse (RN)-A completed the incident report with a post fall analysis indicating R4 lost her balance and fell. Although R4 was out of the facility and had a diagnosis of Alzheimer's dementia, the interventions to prevent further falls included R4 was educated to use the arm of the chair to assist her to get up. - December 2, 2025, hospital progress note indicates R4 had diagnoses of periorbital fracture and atrial fib (fibrillation) with rapid ventricular rate (irregular heart rate) - December 9, 2026, R4 returned to the facility and a change in condition assessment was completed. - January 16, 2026, at 12:05 p.m. staff were assisting R4 to stand from a chair and R4 fell to the floor. Staff were educated to allow R4 to stand by herself instead of helping her up. - January 23, 2026, at 12:28 a.m. R4 had been walking for a couple of hours, began walking too fast and fell forward, breaking her teeth and she bit her lip. R4 was sent to the emergency room. Post fall assessment was completed by licensed assisted living director/registered nurse (LALD/RN)-M on January 23, 2026, at 2:41 p.m. (after another fall with injury had occurred) with an intervention to 'encourage resident to use her walker.' - January 23, 2026 at 4:50 a.m. R4 fell again, she fell backwards and hit her head with a laceration to the left side of the head, and was again sent into the emergency room. Post fall assessment was completed by LALD/RN-M on January 23, 2026 at 5:00 p.m. (after another fall occurred). Although R4 had no diagnosis of seizures, the	01620		

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01620	Continued From page 21 root cause analysis indicated possible seizure. Intervention to prevent further falls was a 'hospice consult and admission.' - January 23, 2026, at 4:15 p.m. R4 was walking with a walker and a blanket. R4 tripped on the blanket causing her to fall. Post fall assessment was completed by LALD/RN-M on January 23, 2026, at 6:03 p.m. with a root cause analysis indicating R4 was ambulating with a walker and a blanket and tripped on the blanket. Interventions to prevent further falls indicated 'staff were encouraged to use as needed medications after they are delivered from the pharmacy/hospice and staff was to monitor closely until then.' - February 14, 2026, at 9:20 a.m. R4 was attempting to ambulate without assistance and fell. Post fall assessment by LALD/RN-M, was not completed until February 18, 2026, (four days later) with the intervention 'chair alarm to be ordered by family.' R4 did not have a chair alarm in place during observations on March 2-4, 2026. - February 24, 2026, at 12:00 a.m. R4 was laying on the floor next to the bed, on her side and her face. R4 sustained a bruise to her right eye and a laceration to the right side of her forehead. Post fall assessment was completed by RN-L on February 24, 2026, at 2:06 p.m. (two days later, after R4 had fallen three more times) indicating R4's right eye was swollen shut with purple bruising. Intervention included a 'request for hospice to complete a medication reconciliation and schedule medications to help with terminal restlessness and pain.' - February 26, 2026, at 7:30 a.m. R4 was trying to get out of bed and fell. The report did not include a description of how R4 was found. Follow up was completed by RN-A on March 2, 2026, at 1:18 p.m. (four days later and after R4 had fallen four more times) indicated the fall was unwitnessed, and it appeared resident got caught	01620		

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01620	Continued From page 22 in her blankets when trying to get out of bed and fell to the floor with her blankets. Interventions included 'increased safety checks and toileting checks.' However, R4's record indicated toileting checks ten times a day and safety checks five times a day; they were not increased after the interventions were identified. - February 26, 2026, at 8:30 a.m. R4 fell in the dining room when she was trying to walk. Post fall assessment was completed by RN-A on March 2, 2026, at 2:53 p.m. (four days later and after resident had fallen three more times). The root cause analysis included resident got out of her wheelchair and was trying to walk on her own, lost her balance and fell. Interventions included 'as needed medications for comfort, safety checks, toileting checks, and reposition with a pillow as appropriate.' - February 26, 2026, at 1:25 p.m. R4 was attempting to stand but "failed". Resident was laying on her back with her head leaning on a rail at the bottom of her wall. Post fall assessment was completed by RN-A on March 3, 2026, at 3:29 p.m. (five days later and after the surveyor requested the records and after R4 had fallen two more times) indicated R4 tried to get up and fell. Interventions included staff to "administer Tylenol, Haldol, morphine for increasing signs and symptoms of pain, agitation, and restlessness. Staff were to be attentive to R4's needs of toileting, repositioning, comfort, pain, and breathing to prevent agitation and attempts to get up unassisted." Although there were no changed noted in R4's services. - R4's progress notes dated February 26, 2026, at 10:03 a.m. indicated RN-L had contacted hospice to request a Broda chair and at 2:11 p.m., RN-L spoke with hospice RN to request an assessment for a fall mat. The notes indicated the hospice RN was told by the previous facility RN that they	01620		

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01620	Continued From page 23 could not use a floor mat because that would create a fall risk. - R4 did not have a Broda chair or a fall mat at the time of the survey. - February 28, 2026, at 4:55 a.m. R4 was trying to get out of bed and was face down on the floor next to the bed. R4 was bleeding from the nose and possibly the mouth. The left side of R4's face under the eye was swollen and there was a skin tear to her right hand. Post fall assessment was completed by RN-A on March 3, 2026, (four days later and after the surveyor requested the records and after R4 had fallen one more time) and interventions were 'a weighted blanket which family had ordered and bed alarm in place'. - February 28, 2026, at 4:23 p.m. R4 was trying to get up from her wheelchair in the dining room and fell. Post fall assessment was completed March 3, 2026, at 3:44 p.m. by RN-A (four days later and after the surveyor requested the records), and interventions included 'Broda chair requested and staff were to monitor when in the wheelchair'. - No changes to the R4's services were identified to include monitoring when she was in her wheelchair. R4's services included: - safety checks at 12 a.m., 2 a.m., 4 a.m., 6 a.m., and 10 p.m. - toileting assistance at 12 a.m., 2 a.m., 4 a.m., 5 a.m., 6 a.m., 8 a.m., 10 a.m., 11 a.m., 2 p.m., 5 p.m., 8 p.m., 10 p.m., and 11 p.m. However the 5 a.m., 11 a.m., and 11 p.m., safety checks were discontinued on February 25, 2026. On March 3, 2026, at 11:54 a.m. R4's hospice registered nurse (RN)-K from an outside agency stated R4 had fallen about eight times in the last week. R4 had been eating and engaging with her (RN-K) last week but over the weekend she was	01620		

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01620	Continued From page 24 noted to decline and was in atrial fibrillation (irregular heart rate). RN-K stated R4 had been admitted to hospice on January 23, 2026, in an effort to decrease falls and injuries. They had rearranged R4's room, brought in a hospital bed, and have had medication changes. RN-K states the previous facility RN would not allow bed rails, foot pedals, or a floor mat. On March 4, 2026, at 12:36 p.m. ULP-D stated R4 had a bed alarm but did not have a chair alarm. On March 4, 2026, at 1:14 p.m. RN-H stated the laceration to the forehead occurred with the fall on February 24, 2026. On March 4, 2026, at 1:44 p.m. operations director/registered nurse (OD/RN)-G stated post fall assessments should have been completed after the falls occurred within 24-48 hours, per policy, to prevent further falls. In addition, interventions should have been followed up on. On March 5, 2026, at 10:59 a.m. OD/RN-G stated the licensee has added a bed alarm and wedges to use in the wheelchair on March 3, 2026. In addition, they requested a Broda chair, but hospice is not able to provide one. If the nurse added interventions such as increasing safety checks, R4's services should have been updated to reflect that change. R4 should be receiving hourly safety checks. The licensee's Assessment-Schedules policy dated January 1, 2025, indicated changes in client condition should be completed as indicated - "Face to Face with the client. 24-48 hours post fall assessment."	01620		

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01620	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action; however, the scope and level remains at J.	01620		
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 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 service plan modifications were completed and signed when the resident's services changed for one of three	01640		

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01640	Continued From page 26 residents (R3) as required. 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: R3 was admitted to the licensee on February 3, 2022, and received assisted living services. On March 3, 2026, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-C feeding R3 her breakfast. R3 was in a reclining wheelchair and was totally dependent for the meal. At 9:13 a.m., the surveyor observed ULP-C and ULP-D using a mechanical full body lift to transfer R3 to her bed, they assisted to change brief and positioned with pillows in the bed. R3 was totally dependent and did not participate in the process. R3's Clinical Update Assessment dated November 18, 2025, indicated R3 received total assist with eating, dressing, grooming, transfers, and medication administration. R3's Service Plan Dated February 1, 2025, indicated R3's services included dressing/grooming set-up or supervision, dietary-meal assistance and behavior- requires redirection. R3's Service Recap Summary dated February	01640		

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01640	Continued From page 27 2026, included dressing/grooming set-up or supervision, dietary-meal assistance, but did not include behavior-requires redirection. R3's dressing/grooming set-up or supervision service description was dated February 3, 2022, and identified "set up appropriate clothing for the resident in a safe accessible location. Set up all necessary grooming tools and materials (tooth brush and tooth paste, dentures and denture creams, hair brush, deodorant, wash cloth, etc) in a safe and accessible location for the resident. Staff will place soiled clothing in the laundry and put supplies away when finished" R3's dietary-meal assistance service description was dated September 5, 2024, and identified "Staff will provide set-up or physical assistance to eat during meals/snacks as needed". On March 4, 2026, at 9:45 a.m., operations director/registered nurse (OD/RN)-G stated dressing, grooming, and meal assistance should have been total assistance and behavior management was not an active service. OD/RN-G stated the service plan should have been updated when changes in services occurred. The licensee's Service Plans policy dated January 1, 2025, included the following: - The service plan must be revised, if needed, based on the results of required client monitoring and/or reassessments. - the licensee will implement and provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01640		

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01640	Continued From page 28 (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure as needed (PRN) medications included documentation for effectiveness after administration for one of one (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760		

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01760	Continued From page 29 On March 2, 2026, at 4:15 p.m., unlicensed staff (ULP)-I exited R4's room pushing her in a reclining wheelchair. R4 was admitted on December 7, 2024, with diagnoses including Alzheimer's disease and atrial fibrillation (irregular heart rate). R4's hospice Care Plan Summary indicted R4's medications included the following: - morphine (narcotic pain medication) 15 mg (milligram) give half a tablet every hour as needed (PRN) for pain or shortness of breath; and - haloperidol (antipsychotic) 1 mg one tablet every two hours PRN. R4's medication administration record (MAR) dated March 1-3, 2026, indicated the following: - March 1, 2026, at 10:58 p.m., morphine was administered for pain. There was no documentation R4 was evaluated for effectiveness of the medication; and - March 2, 2026, at 7:06 a.m., morphine and haloperidol were administered for pain. There was no documentation R4 was evaluated for effectiveness of the medications. On March 2, 2024, at 11:10 a.m., unlicensed personnel (ULP)-B stated after staff administer a PRN medication, the system automatically triggers them to follow up in half to one hour for effectiveness. Staff are to check with the resident for effectiveness and document. On March 4, 2026, at 10:45 a.m., operations director/registered nurse (OD/RN)-G stated staff are to follow up in an hour for effectiveness after administering as needed medications and	01760		

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01760	Continued From page 30 document the follow up. The licensee's PRN Medications policy dated November 25, 2026, included: "Document on the PRN medication record: a. when the PRN medication was given b. why the PRN medication was given c. any unusual reactions or symptoms following the administration of the medication. d. follow up communication with client". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	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 the licensee's medications were securely locked permitting only authorized personnel to have access for one of five residents (R9). 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	01880		

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01880	Continued From page 31 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 2, 2026, at 12:30 p.m., unlicensed personnel (ULP)-B stated some of the residents had some of their medications locked in a drawer in their room. Typically the medications were inhalers, eye drops, or creams. During that time, the surveyor observed a cabinet drawer in R9's room. ULP-B stated the lock is broken and opened the drawer. In the drawer was a breo-elipta inhaler and a ventolin inhaler. R9 was admitted on March 28, 2023, and received assisted living services. R9's medication management plan dated January 30, 2026, indicated all medications were to be kept secured in the medication cart or medication room at all times. On March 4, 2026, at 11:11 a.m., operations director/registered nurse (OD/RN)-G stated all medications should have been locked in the medication cart. The licensee's Storage of Medications policy dated November 3, 2025, indicated the licensee stores client's (resident's) medications in locked medication cabinets, or locked medication carts. Stored medications are kept always locked other than while a staff person is present at the time of medication administration or medication management. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 32 days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee ailed to ensure time sensitive medications were labeled with the date opened for one of one resident (R9), failed to ensure medications were maintained bearing the original prescription label for one of one resident (R9), and failed to ensure medications were stored at the correct temperature per the medication manufacturer recommendations. 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: Labeling and time sensitive medications. On March 2, 2026, at 12:30 p.m., unlicensed	01890		

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01890	Continued From page 33 personnel (ULP)-B stated some of the residents had some of their medications locked in a drawer in their room. Typically the medications were inhalers, eye drops, or creams. On March 2, 2026, at 12:30 p.m., the surveyor observed a cabinet drawer in R9's room. ULP-B stated the lock is broken and opened the drawer. Inside the drawer was a Breo Ellipta inhaler and a ventolin inhaler, both open and in use. Neither inhaler had a pharmacy label or an open date. On March 3, 2026, at 11:11 a.m., operations director/registered nurse (OD/RN)-G stated all medications should have a pharmacy label and time sensitive medications should be dated when they are opened. Breo Ellipta's prescribing information dated May 2017, included "Discard BREO ELLIPTA 6 weeks after opening the foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first". Ventolin prescribing information dated December 2014, included "Throw the inhaler away when the counter reads 000 or 12 months after you opened the foil pouch, whichever comes first". Refrigerator temperatures On March 2, 2026, at 11:00 a.m., ULP-B went to the medication refrigerator and opened the door to remove insulin. The temperature on the thermometer read 50 degrees Fahrenheit. ULP-C stated she did not know what the temperature should be and did not adjust the temperature. The refrigerator included R8's Homology insulin. ULP-B removed the insulin from the refrigerator and administered it to R8.	01890		

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01890	Continued From page 34 The licensee's Fridge/Freezer Temp Log for February 2026, indicated the following: "- All food placed in the refrigerator or freezer should be dated with the date it was initially placed in the refrigerator or freezer. - Discard any outdated food and any prepared food after 3 days- day one is the day it is placed in the refrigerator. - Store completed temp logs in the kitchen readiness binder. - Freezer temperatures need to remain between O*- 10* Refrigerator temperatures need to remain between 35*- 45*" The document did not indicate the correct temperature storage for medications was completed February 1-13, 2026. On February 13, 2026, the temperature was recorded as 50 degrees. There were not any recorded temps after that date. The log did not indicate if anything had been done for the temperature of 50 degrees. On March 3, 2026, at 11:09 a.m., registered nurse (RN)-H stated the temperature for the medication refrigerator should have been between 36 degrees and 46 degrees. If it was at 50 degrees, staff should have adjusted the temperature. Homology prescribing information dated 2007, indicated unopened Homology should be stored in a refrigerator (36° to 46°F [2° to 8°C]), but not in the freezer. Do not use Homology if it has been frozen. In-use Homology vials, cartridges, pens, and Homology KwikPen should be stored at room temperature, below 86°F (30°C) and must be used within 28 days or be discarded, even if they still contain Homology. The licensee's Storage of Medications policy	01890		

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01890	Continued From page 35 dated November 3, 2025, indicated all medications are stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940		

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01940	Continued From page 36 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a written statement of the treatment on the service plan for the licensee's two residents (R3, R8)receiving a pureed diet. 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: R3 R3 was admitted on February 3, 2022, and resided in the memory care area of the facility. On March 2, 2026, at 12:25 p.m., the surveyor observed unlicensed personnel (ULP)-C feeding R3 a pureed diet. On March 3, 2026, at 8:04 a.m., the surveyor observed ULP-C feeding R3 her breakfast. ULP-C stated the kitchen did not send pureed so she was going to mash it. ULP-C mashed some pancakes with a fork and fed it to R3. R3's Clinical Update Assessment dated	01940		

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01940	Continued From page 37 November 18, 2025, indicated R3 received total assist with pureed diet. R3's Service Plan Dated February 1, 2025, indicated R3's services included dietary-meal assistance. There was no indication R3 received a pureed diet. R3's Dietary-meal assistance service description dated September 5, 2024, identified "Staff will provide set-up or physical assistance to eat during meals/snacks as needed". There was no indication R3 received a pureed diet. R8 R8 was admitted on October 23, 2020, and resided in the memory care area of the facility. On March 2, 2026, at 12:25 p.m., the surveyor observed R8 eating a pureed diet independently. On March 3, 2026, at 8:04 a.m., ULP-C stated the kitchen did not send a pureed meal so she would cut it up really small, and served R8 a pancake cut into small pieces. R8's service plan dated February 1, 2025, included assist with bathing, medication management, and behavior management. R8's service plan did not indicate R8 had a pureed diet. On March 3, 2026, at 2:33 p.m., ULP-C told the surveyor R8 had trouble eating regular foods and ground so she had been told by the licensee's nurse they had an order for pureed food and instructed to feed R8 a pureed diet. On March 3, 2026, at 3:50 p.m., operations	01940		

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01940	Continued From page 38 director/registered nurse (OD/RN)-G stated pureed diet for R3 was not on her service plan and it should have been. OD/RN-G stated she did not know when or why R8 changed to a pureed diet but she would look into it. OD/RN-G further stated R8 did not have an order for a pureed diet in her record and the service plan indicated a regular diet. The licensee's Treatment and Therapy Services policy dated January 1, 2025, included: "1) The RN will conduct a face-to-face assessment with the client and develop an individualized Treatment and Therapy Service plan including: a. A statement of the Treatments and Therapies that will be provided b. Frequency of service c. Service providers d. Supervisory Services by the Registered Nurse 2) The RN will verify that all the client's treatment and therapy orders have current prescribers' orders on file in their chart." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	1790 COLLEGEWAY WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 39 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they had treatment orders for one of two residents (R8) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 was admitted on October 23, 2020, and resided in the memory care area of the facility. On March 2, 2026, at 12:25 p.m., the surveyor observed R8 eating a pureed diet independently. On March 3, 2026, at 8:04 a.m., unlicensed personnel (ULP)-C stated the kitchen did not send a pureed meal so she would cut it up really small, and served R8 a pancake cut into small pieces. R8's service plan dated February 1, 2025, included assist with bathing, medication management, and behavior management. R8's service plan did not indicate R8 had a pureed diet. On March 3, 2026, at 2:33 p.m., ULP-C told the	01970		

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	30345	A. BUILDING: _____ B. WING _____	03/06/2026

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01970	Continued From page 40 surveyor R8 had trouble eating regular foods and ground so she had been told by the licensee's nurse R8 had an order for pureed food and instructed to feed R8 a pureed diet. On March 3, 2026, at 3:50 p.m., operations director/registered nurse (OD/RN)-G stated pureed diet was not on R8's service plan and it should have been. OD/RN-G stated she did not know when or why R8 changed to a pureed diet, but she would look into it. OD/RN-G further stated R8 did not have an order for pureed diet in her record and the service plan indicated a regular diet. The licensee's Treatment and Therapy Services policy dated January 1, 2025, included: "1) The RN will conduct a face-to-face assessment with the client and develop an individualized Treatment and Therapy Service plan including: a. A statement of the Treatments and Therapies that will be provided b. Frequency of service c. Service providers d. Supervisory Services by the Registered Nurse 2) The RN will verify that all the client's treatment and therapy orders have current prescribers' orders on file in their chart." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the	02110		

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02110	Continued From page 41 assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required for assisted living facilities with dementia	02110		

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02110	Continued From page 42 care (ALFDC) were developed and provided to each resident and/or the resident's legal and designated representative at the time of move-in. 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: The licensee had an assisted living with dementia care license effective August 1, 2021. The licensee lacked the the required ALFDC dementia policies: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 43 efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On March 4, 2026, at 3:25 p.m., operations director/registered nurse (OD/RN)-G stated the licensee had not been using the correct dementia care policies in this facility. OD/RN-G further stated they should have been using the correct policies, and they should have been provided to residents and responsible parties upon admission and included on the acknowledgement form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to	02140		

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02140	Continued From page 44 oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all 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, 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: The licensee was licensed as an assisted living facility with dementia care (ALFDC). During the entrance conference on March 2, 2026, at 1:46 p.m., operations director/registered nurse (OD/RN)-G stated clinical nurse supervisor (CNS)-A was the supervising staff overseeing/providing staff training. CNS-A's employee record included an EduCare transcript that identified CNS-A had completed two online EduCare modules: Alzheimer's Disease and Other Types of Dementia. CNS-A's transcript did not include the required EduCare's 5-part Dementia Series. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed and included "For subscribers of EduCare, EduCare's 5-part Dementia Series	02140		

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02140	Continued From page 45 and test may be used to meet the statutory requirement." On March 4, 2026, at 4:25 p.m., OD/RN-G stated the assisted living director was the supervisor who should have the required dementia training. CNS-A only had the provided EduCare training not the required 5-part series. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice for three of three residents (R7, R6, R11). 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	02320		

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02320	Continued From page 46 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: R7 On March 2, 2026, at 11:04 a.m., the surveyor observed ULP-B preparing R7's insulin pen for administration. ULP-B removed the cap, opened a pen needle and secured it to the insulin pen. ULP-B did not clean the port on the insulin pen prior to attaching the needle. On March 3, 2026, at 11:11 a.m., operations director/registered nurse (OD/RN)-G stated staff should have cleaned the insulin pen port prior to attaching the pen needle. The licensee's Insulin policy dated November 3, 2025, included "Clean the top of the bottle or pen tip with an alcohol swab." R6 On March 2, 2026, at 10:19 a.m., the surveyor observed unlicensed personnel (ULP)-B administering medications to R6. ULP-B set up R6's medications for administration which included one acetaminophen 650 mg tablet. ULP-B placed the medication in R6's hand with his other medications. R6 asked ULP-B to break the acetaminophen tablet. ULP-B picked up the tablet stating she forgot and would have to get a pill cutter from the medication cart. R6 took it back from her, bit the tablet in half and swallowed the medication. On March 2, 2026, at 10:20 a.m., ULP-B stated she typically cuts the pill in half using a pill cutter	02320		

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02320	Continued From page 47 from the medication cart prior to bringing the medication to R6. R6's physician orders dated October 6, 2025, included acetaminophen 650 mg tablet take one tablet by mouth three times a day. The order did not indicate it was ok to break or cut the tablet. R6's medication administration record (MAR) dated March 2026, included acetaminophen 650 mg tablet take one tablet by mouth three times a day. The MAR did not indicate staff were to break or cut the tablet. On March 4, 2026, at 9:07 a.m., registered nurse (RN)-H stated staff should not be cutting R6's acetaminophen as it is extended release. RN-H further stated there is no documentation on the MAR or in R6's record instructing staff to break or cut the pill. Tylenol (acetaminophen) Arthritis Medication 650 mg tablet label dated 2018, includes "swallow whole; do not crush, chew, split, or dissolve." R11 On March 3, 2026, at 10:35 a.m., the surveyor observed ULP-B completing wound care to R11. ULP-B removed R11's old bandage from the right heel, opened a barrier wipe and applied to the wound. ULP-B cut a piece a small square of Hydrofera Blue foam dressing, cut a piece of fabric tape, placed the foam dressing in the center of the fabric tape and applied it to the back of R11's right heel wound. ULP-B did not clean or soak the wound between removal of the old dressing and placement of the new dressing. R11's physician dated June 25, 2025, included: "Right Calcaneus wound:	02320		

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02320	Continued From page 48 Vashe: Let soak on wound for 5-10 min Do not rinse off. AllKare Protective Barrier Wipes-Use 1 daily to apply to peri (around) wound skin Hydrofera Blue Ready: cut dressing to fit just over the wound. Apply Hydrofera Blue Ready to wound bed with words away from skin, facing outward to read. Secure with Medipore Soft Cloth Surgical Tape." R11's service description dated February 26, 2026, included: "Right Calcaneus wound: Vashe: Let soak on wound for 5-10 min Do not rinse off. AllKare Protective Barrier Wipes-Use 1 daily to apply to peri (around) wound skin Hydrofera Blue Ready: cut dressing to fit just over the wound. Apply Hydrofera Blue Ready to wound bed with words away from skin, facing outward to read. Secure with Medipore Soft Cloth Surgical Tape ." On March 3, 2026, at 4:15 p.m., clinical nurse supervisor (CNS)-A stated the wound should have been soaked prior to applying the new dressing. CNS-A stated she had trained staff to put the Vashe solution on a 4x4 gauze and rest the heel on the gauze, and ULP-B should have completed that step. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Golden Horizons
1790 College Way
Worthington, MN 56187
Nobles County
Parcel:

Phone:

License Info

License: HFID 30345

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7990261002
Inspection Type: Full - Single
Date: 3/2/2026 Time: 10:21:22 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 7
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: THE ESTABLISHMENT NEEDS AN MDH STATE ISSUED CFPM LICENSE HOLDER. DAWN HAS A TRAINING CERTIFICATE FROM 2024 BUT DOES NOT HAVE AN MDH CFPM LICENSE.
Comply By: 4/2/2026 Originally Issued On: 3/2/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: DISCONTINUE STORING FOOD ON THE FLOOR IN THE DRY STORAGE ROOM, WALK IN COOLER, AND WALK IN FREEZER.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: REMOVE WOOD HANDLED KNIFE AND OTHER WOOD HANDLED UTENSILS FROM THE KITCHEN.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: PROVIDE A CHLORINE SANITIZER TEST KIT TO MONITOR SANITIZER CONCENTRATION FOR THE DISH MACHINE.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: HANDWASH SINK NEEDS TO BE REPAIRED TO RE-SEAL TO THE WALL SURFACE.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

! New Order: 4-600 Cleaning Equipment and Utensils
4-602.11C *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0845C Clean food-contact surfaces of equipment and utensils used for TCS foods, at least every 4 hours.
COMMENT: CLEAN AND MAINTAIN CLEAN THE INSIDE OF THE TOASTER.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-303.11B *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1470B Provide at least 20 foot candles (215 LUX) of light intensity at a distance of 30 inches from the floor for areas where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged foods are sold or offered for consumption, inside equipment including reach-in and under counter refrigerators, in utensil storage areas, warewashing areas, and in toilet rooms.
COMMENT: REPLACE BURNT OUT LIGHT BULB INSIDE TRUE REACH IN COOLER ON GRILL LINE.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: CLEAN AND MAINTAIN CLEAN THE CEILING AND AIR VENT AREA ABOVE THE MICROWAVE AND TOASTER AND THE AREA UNDER AND BEHIND THE GRILL LINE EQUIPMENT AS DISCUSSED WITH DAWN.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.16 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.
COMMENT: DISCONTINUE STORING THE MOP SITTING WET IN THE MOP SINK. HANG THE MOP TO DRY AS DISCUSSED WITH DAWN.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

Food & Beverage General Comment

DAWN AND I DISCUSSED THE NEED FOR A FOLLOW UP INSPECTION NEXT WEEK.

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 Mankato District Office inspection report number F7990261002 from 3/2/2026

Benjamin D. Ische

Dawn

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Golden Horizons
Worthington
County/Group: Nobles County

Inspection Info

Report Number: F7990261002
Inspection Type: Full
Date: 3/2/2026
Time: 10:21:22 AM

Equipment Temperature: Product/Item/Unit: Butter**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 40 Degrees F.
Comment: Hoshizaki Cooler
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Ambient Air
Location: Reach-in Cooler at 41 Degrees F.
Comment: Memory Care Frigidaire Cooler
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

Golden Horizons
Worthington
County/Group: Nobles County

Inspection Info

Report Number: F7990261002
Inspection Type: Full
Date: 3/2/2026
Time: 10:21:22 AM

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

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Golden Horizons
1790 College Way
Worthington, MN 56187
Nobles County
Parcel:

Phone:

License Info

License: HFID 30345

Risk:
License:
Expires on:
CFPM: Jillian O'Brien-Tadych
CFPM #: 26808; Exp: 8/4/2028

Inspection Info

Report Number: F7990261003
Inspection Type: Follow-up - Single
Date: 3/9/2026 Time: 10:13:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

All orders from the previous inspection have been corrected and cleared from this report.

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 Mankato District Office inspection report number F7990261003 from 3/9/2026

Benjamin D. Ische

Dawn

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30345016-0	**Date:** 3/5/2026
Facility Name: Golden Horizons	
Facility Address: 1790 COLLEGE WAY, WORTHINGTON, MN	

☒ **TAG IDENTIFICATION: 0775**

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

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

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

   Comments: Several resident room fire doors equipped with self-closing hinges no longer worked, preventing the door from closing and latching.

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

   Comments: During testing of resident room smoke alarms throughout the facility it was observed that the alarm in resident room #122 was over 10 years old from the manufacture date.

☒ **TAG IDENTIFICATION: 0810**

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

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

Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. 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: Surveyor requested evacuation drill documentation from the operations director/registered nurse (OD/RN)-G personnel. Licensee provided fire drill documents from August 2025 and after only. Documents provided show drills didn't occur twice per year, per shift with at least one evacuation drill every other month*. No other information or documentation was provided.*