



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 11, 2026

Licensee

Villa Vista and Cardinal Court
1220 Villa Court Drive
Cromwell, MN 55726

RE: Project Number(s) SL30721016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Villa Vista and Cardinal Court. **Please contact Jessie Chenze at 218-332-5175 on or before Monday June 15, 2026, to schedule the conference call.**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEpHVva>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
(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: SL3021016-0 On April 21, 2026, through April 24, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 46 residents; 46 receiving services under the Assisted Living Facility license. An immediate correction order was identified on April 22, 2026, issued at a widespread scope and level three (I) for tag identification 1290; the licensee took mitigating action on April 23, 2026, however, the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100			

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0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate a therapy agency. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on April 21, 2026, at 10:30 a.m. through 11:39 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living	0 100			

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0 100	Continued From page 3 requirements. LALD-A stated the licensee did not employ physical, speech or occupational therapists; however, had a therapy agency that leased office space located in the building on the 2nd floor. LALD-A and CNS-B stated the therapy agency did not have a separate entrance into the building and provided services to residents in the assisted living and served clients in the community. LALD-A stated the therapy agency was not affiliated with the licensee and only leased office space in the building. On April 21, 2026, at 11:58 a.m. the surveyor toured the facility with another surveyor and CNS-B. The assisted living building consisted of three levels. During the facility tour, the surveyors observed an office with the name of a therapy agency located in room 207 on the second floor of the building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
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	0 470			

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0 470	Continued From page 4 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice a year. 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 held an assisted living facility	0 470			

Minnesota Department of Health

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0 470	Continued From page 5 license for a capacity of 56 residents and had a current census of 46 residents. During the entrance conference on April 21, 2026, at 11:39 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On April 22, 2026, at 11:25 a.m., LALD-A provided a handwritten staffing plan on a piece of paper and stated LALD-A just completed the licensee's staffing plan and was unsure if completed correctly. LALD-A stated the licensee had not developed or implemented a formula to determine staffing hours based on resident care needs. The licensee's Staffing and Scheduling policy dated August 2021, indicated the supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			

Minnesota Department of Health

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0 480	Continued From page 6	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 21, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480			

Minnesota Department of Health

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0 480	Continued From page 8 Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during medication administration for one of three employees (unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 510			

Minnesota Department of Health

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0 510	Continued From page 9 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had hire date of August 11, 2021, to provide care and services to the residents of the licensee. ULP-E's employee record indicated ULP-E completed annual infection control training July 22, 2025, and was supervised by clinical nurse supervisor (CNS)-B during a medication administration observation on July 22, 2025. On April 22, 2026, at 7:22 a.m., the surveyor observed ULP-E put on a pair of gloves, crush R6's medications into a powdery substance, mixed the crushed medications into pudding, administer R6's medications at the dining table and document R6's medication administration in the EMAR (electronic medical administration record). At 7:22 a.m., wearing the same pair of gloves and without performing hand hygiene, ULP-E prepared R7's and administered R7's morning medications in the dining room and documented R7's medication administration in the EMAR. At 7:27 a.m., ULP-E prepared R3's medications, opened a medication capsule and crushed the remaining of R3's medications into a powdery substance, mixed with pudding and administered R3's medications in the dining room. ULP-E documented R3's medication administration in the EMAR, removed gloves and without performing hand hygiene, ULP-E proceeded to assist and serve resident's breakfast in the dining room. On April 22, 2026, at 7:37 a.m., ULP-E stated ULP-E was unsure if changing gloves in between	0 510			

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0 510	Continued From page 10 administering resident medications was required and stated at a minimum ULP-E should have used hand sanitizer or not have worn gloves at all. On April 23, 2026, at 4:12 p.m., CNS-B stated staff were not required to wear gloves during medication administration; however, staff were expected to perform hand hygiene before and after administering resident medications. The licensee's Administration of Oral Medications policy dated December 15, 2008, indicated to wash hands in accordance with policy before passing medications and at anytime in the process that they may have been contaminated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
(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
0 630	Continued From page 11 by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 21, 2026, at 11:39 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R3 R3's diagnoses included diabetes type 2, dementia, mood disorder, hypertension (high blood pressure), chronic kidney disease, and hemiplegia (partial loss of one side of the body). R3's record included a Service Plan dated November 30, 2023; however, the service plan lacked a list of services to be provided. R3's April 2026 Service Recap Summary dated April 1, through April 22, indicated R3 was scheduled and received the following services: medication administration, bathing, dressing,	0 630			

Minnesota Department of Health

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0 630	Continued From page 12 grooming, toileting, transferring and mobility, laundry and housekeeping. On April 22, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's scheduled morning medications. R3's 90-Day Assessment dated February 25, 2026, indicated R3 was at risk to be abused and at risk of abusing other vulnerable adults; however, R3's assessment did not include a review of R3's risk of self-abuse. R4 R4's diagnoses included diabetes type II, chronic kidney disease, and major depressive disorder. R4's record included a Service Plan dated October 11, 2019; however, the service plan lacked a list of services to be provided. R4's April 2026 Service Recap Summary dated April 1, through April 22, indicated R4 was scheduled and received the following services: medication administration, blood glucose monitoring, bathing, dressing, grooming, toileting, transferring and mobility, laundry and housekeeping. R4's 90 Day Assessment dated April 1, 2026, indicated R4 was not at risk to abuse other venerable adults and had no history of attempted suicide or thoughts of suicide; however, R4's assessment lacked R4's susceptibility to abuse by others. On April 23, 2026, at 3:58 p.m., CNS-B stated CNS-B was aware of the required content in an IAPP assessment/evaluation. CNS-B reviewed	0 630			

Minnesota Department of Health

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0 630	Continued From page 13 R3 and R4's assessment and stated all the required content should be addressed in a resident assessment since the licensee used Residex (electronic health record) and CNS-B would have to look into it further. The licensee's Vulnerable Adult Risk Assessment and Plan and Individual Abuse Prevention Plan policy dated February 11, 2025, indicated the licensee would develop an individual abuse prevention plan for each resident, to be incorporated into the care plan including specific measures to minimize the risk of abuse for each resident including areas of vulnerability of being harmed or harming others. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650			

Minnesota Department of Health

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0 650	Continued From page 14 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records were maintained to include the required content for two of three employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 21, 2026, at 11:39 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B and office manager (OM)-C stated the licensee was aware of required contents for an employee record. CNS-B CNS-B had a hire date of January 2, 1976, under	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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0 650	Continued From page 15 the licensee's prior license types to provide and supervise direct care services to the licensee's residents and continued under the assisted living license on August 1, 2021. During the course of the survey, CNS-B was observed providing care and services to the residents at the facility. CNS-B's employee record included a Nurse Manager Performance Appraisal dated January 25, 2023; however, CNS-B's record lacked evidence CNS-B had annual performance reviews completed in 2024 and 2025. ULP-E ULP-E had a hire date of July 11, 2021, to provide care and services to the residents at the facility. On April 22, 2026, at 7:18 a.m., the surveyor observed ULP-E administering R6's morning medications. ULP-E's employee record included an annual performance review dated February 28, 2022; however, lacked evidence ULP-E had a current annual performance review completed since 2022. On April 23, 2026, at 2:50 p.m., OM-C stated OM-C was unable to find a current annual performance review completed for CNS-B or ULP-E. OM-C stated CNS-B was responsible for completing ULP's performance reviews. On April 24, 2026, at 10:14 a.m., LALD-A stated LALD-A was responsible for completing CNS-B's annual performance review; however, had not completed a performance review for CNS-B on paper since 2023.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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0 650	Continued From page 16 The licensee's Personnel Records policy dated February 2019, indicated personnel records would be kept up-to-date, well organized and confidential. A personnel file would for each person would include performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which	0 660			

Minnesota Department of Health

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0 660	Continued From page 17 included a current facility TB risk assessment. 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: During the entrance conference on April 21, 2026 , at 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B, stated they believed a TB risk assessment had been completed by LALD-A. The licensee's TB Risk Assessment dated September 2024, indicated the facility was a low risk level. On April 16, 2026, at 2:30 p.m., LALD-A stated she was unable to complete a current TB Risk Assessment prior to the start of the survey. The licensee's Tuberculosis Screening policy reviewed February 4, 2026, noted the licensee would maintain a current community TB risk assessment updated annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an	0 660			

Minnesota Department of Health

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0 660	Continued From page 18 annual facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 21, 2026, for the specific violations related the physical environment under Minnesota Statute	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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0 775	Continued From page 19 144G.	0 775			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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0 800	Continued From page 20	0 800			
0 810 SS=E	21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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 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.	0 810			

Minnesota Department of Health

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0 810	Continued From page 21 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01290	Continued From page 22 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of three employees (housekeeper (H)-G) and one of one regularly scheduled volunteers (V)-H. This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on April 22, 2026. During the entrance conference on April 22, at 10:30 a.m. office manager (OM)- C stated the licensee was aware of required contents in an employee record.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01290	Continued From page 23 The licensee's NETStudy 2.0 Roster printed April 21, 2026, did not include H-G or V-H as employees of the licensee. HOUSEKEEPER H-G was hired on June 23, 2025, to provide dietary, housekeeping, and laundry services for the residents at the facility. H-G's Payroll Summary dated April 1, through April 22, 2026, indicated H-G worked 2.5 hours in dietary and 14 hours in housekeeping/laundry for a total of 16.5 hours. H-G's employee record lacked a current cleared background study for the licensee. On April 22, 2026, at 8:30 a.m., the surveyor reviewed the employee roster with OM-C and confirmed H-G was a part-time employee of the license and provided dietary and housekeeping services for the residents and H-G was not under direct supervision at all times when working. The surveyor reviewed the licensee's NETStudy 2.0 Roster with OM-C and OM-C verified H-G was not listed on the licensee's NETStudy 2.0 Roster. OM-C stated the licensee paid for H-G's background application; however, OM-C was unclear why H-G was not included on the licensee's DHS employee roster. VOLUNTEER V-H On April 22, 2026, at 7:30 a.m., V-H was observed in the Cardinal dining room helping serve resident's breakfast. At 7:39 a.m., the surveyor observed V-H cutting R2's food then V-H sat in a chair next to R2 and provided total	01290			

Minnesota Department of Health

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01290	Continued From page 24 feeding assistance to R2. On April 22, 2026, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated V-H worked as the licensee's activities director several years ago and currently volunteers on Wednesdays at the facility. CNS-B stated the facility has a salon and V-H volunteered once a week doing resident's hair. On April 22, 2026, at 9:41 a.m., OM-C stated V-H was not a current employee of the licensee and volunteered on Wednesdays in the beauty shop doing resident's hair. OM-C stated V-H had been a previous activities director at the facility and retired over 12 years ago and has since had been volunteering at the facility in different capacities and V-H did not have a current background study completed under the licensee. The licensee's Background Checks policy date May 27, 2020, no staff, regularly scheduled volunteer (10+ hours per week), or contractor shall be permitted to have unsupervised direct contact or access with clients of licensee until results from a MN DHS Background Study (NetStudy 2.0) permitting the staff, regularly scheduled volunteer or contractor to have independent contact with home care clients (e.g.: passed the background study) are received. The licensee would utilize the Minnesota Department of Human Services (MN DHS) background study process. Optional - External background checks are permitted, but will NOT replace the need for a MN DHS background study. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 25 program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01500	Continued From page 26 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
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01500	Continued From page 27 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-E, maintenance manager (MM)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 21, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A and CNS-B stated the licensee was aware of the required contents in an employee record. CNS-B CNS-B had a hire date of January 2, 1976, to supervise and provide direct care services to the residents at the facility.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01500	Continued From page 28 On April 22, 2026, at 7:00 a.m., the surveyor observed CNS-B administering R7's scheduled medications. CNS-B's employee record lacked the following required annual training topics: -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; and -the principles of person-centered planning and service delivery ULP-E ULP-E had a hire date of July 11, 2021, to provide direct care and services to the residents at the facility. On April 22, 2026, at 7:27 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications. ULP-E's employee record lacked the following required annual training topics: -review of provider's policies and procedures; and -principles of person-centered planning and service delivery MM-D MM-D was hired on June 5, 2014 , and began to provide direct care services to residents at the assisted living facility August 1, 2021. On April 22, 2026, at 08:10 a.m., the surveyor observed MM-D pass out meal trays to several residents in the dining area. MM-D's employee record lacked the following required annual training topics: -assisted living bill of rights;	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01500	Continued From page 29 -review of infection control techniques; and -the principles of person-centered planning and service delivery. On April 23, 2026, at 2:50 p.m., office manager (OM)-C stated MM-D was cross-trained and occasionally worked as an ULP as well as completed maintenance duties. OM-C stated CNS-B, ULP-E and MM-D had not been assigned or completed the annual training topics noted above. The licensee's Staff Competency Training and Evaluation, and Annual Education policies dated August 4, 2021, indicated all staff that perform direct care services at [licensee name] will complete required annual in-services and this will be kept in the licensee's Annual Education Training folder for each 12 months of employment. In addition, the policy included required annual training for the above noted topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
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01530	Continued From page 30 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for three of three employees (clinical nurse	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01530	Continued From page 31 supervisor (CNS)-B, unlicensed personnel (ULP)-E, ULP-K). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 21, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A, CNS-B and office manager (OM)- C stated the licensee was aware of the required contents in an employee record. CNS-B CNS-B had a hire date of January 2, 1976, to supervise and provide direct care services to the residents at the facility. On April 22, 2026, at 7:00 a.m., the surveyor observed CNS-B administering R7's scheduled medications. ULP-E ULP-E had a hire date of July 11, 2021, to provide direct care and services to the residents at the facility. On April 22, 2026, at 7:27 a.m., the surveyor observed ULP-E administering R3's scheduled morning medications.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01530	Continued From page 32 ULP-K ULP-K had a hire date of May 19, 2025, to provide direct care and services to the residents of the licensee. CNS-B, ULP-E and ULP-K's employee records lacked documentation of the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. On April 23, 2026, at 2:50 p.m., OM-C stated no employees had been assigned or completed mental illness and de-escalating training and thought topics were covered in the dementia training provided by the hospice agency. The licensee's Personnel Records policy dated February 2019, indicated personnel records would be kept up-to-date, well organized and confidential. A personnel filed would for each person would include records of all required training and in-service education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8),	01550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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01550	Continued From page 33 within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure non-direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of one employee (housekeeper (HSKP)-G). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 21, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B and office manager (OM)-C stated the licensee was aware of the required contents in an employee record. HSKP-G had a hire date of June 23, 2025, to provide dietary, housekeeping and laundry	01550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
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01550	Continued From page 34 services to the residents at the facility. HSKP-G's employee record lacked documentation HSKP-G completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. On April 23, 2026, at 2:50 p.m., OM-C stated no employees had been assigned or completed mental illness and de-escalating training and thought the topics were covered in the dementia training provided by the hospice agency which provided dementia training for the licensee. The licensee's Personnel Records policy dated February 2019, indicated personnel records would be kept up-to-date, well organized and confidential. A personnel file would for each person would include records of all required training and in-service education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550			
01620 SS=E	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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
(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
01620	Continued From page 35 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 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.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing comprehensive nursing assessments not to exceed every 90 days for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 21, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the RN completed resident assessments on preadmission, at admission, 14 days after admission, and then at least every 90 days unless the resident had a change of condition or hospitalization. R2 R2 was admitted to the facility on August 27, 2024, and received the following services: medication administration, dressing, grooming, bathing, toileting, incontinence care, bed mobility, transfers, housekeeping and laundry. R2's diagnoses included Parkinsonism, chronic obstructive pulmonary disease, hypertension	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
(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
01620	Continued From page 37 (high blood pressure), essential tremor, and major depressive disorder. On April 22, 2026, at 7:38 a.m., the surveyor observed volunteer (V)-H assist R2's with breakfast. R2's record included a 90-Day Assessment dated October 30, 2025, and February 3, 2026 (96 days past due). R4 R4 was admitted to the facility on October 11, 2019, and received the following services: medication administration, dressing, grooming, bathing, toileting, transferring, housekeeping and laundry. R4's diagnoses included type II diabetes, chronic kidney disease and major depressive disorder. R4's record included a 90-Day Assessment dated December 22, 2025, and April 1, 2026, (10 days past due). R2 and R4's record lacked evidence of a 90-day reassessment completed by an RN in the required time frame. On April 23, 2026, at 3:48 p.m., CNS-B stated the licensee used electronic medical records for residents, which prompted the RNs to know when assessments were due. CNS-A stated residents assessment should be completed within 90 days from the previous assessment and was unsure why R2 and R4's assessment were not completed timely. No further information was provided.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726		
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01620	Continued From page 38	01620			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 39 develop and maintain service plans to include all required content for two of two resident (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on April 21, 2026, at 10:30 a.m., clinical nurse manager (CNS)-B stated the nurses were responsible for developing and maintain the resident service plans. R2 R2 was admitted to the facility on August 27, 2024. R2's diagnoses included Parkinsonism, chronic obstructive pulmonary disease, hypertension (high blood pressure), essential tremor, and major depressive disorder. On April 22, 2026, at 7:38 a.m., the surveyor observed volunteer (V)-H assist R2's with breakfast. R2's April 2026 Service Recap Summary dated April 1, through April 22, indicated R2 was scheduled and received the following services: medication administration, dressing, grooming, bathing, toileting, incontinence care, bed mobility, transfers, safety checks, behavior management, therapeutic exercises, housekeeping and laundry.	01650			

Minnesota Department of Health

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01650	Continued From page 40 R2's record included a Service Plan dated June 23, 2022; however, the service plan lacked a description and frequency of services to be provided, fees for services, and persons who are to provide the services. R3 R3 was admitted on December 1, 2023. R3's diagnoses included diabetes type 2, dementia, mood disorder, hypertension (high blood pressure), chronic kidney disease, and hemiplegia (partial loss of one side of the body). On April 22, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's scheduled morning medications. R3's April 2026 Service Recap Summary dated April 1, through April 22, indicated R3 was scheduled and received the following services: medication administration, bathing, dressing, grooming, toileting, transferring and mobility, laundry and housekeeping. R3's record included a Service Plan dated November 30, 2023; however, the service plan lacked a description and frequency of services to be provided, fees for services, and persons who are to provide the services. On April 23, 2026, at 10:08 a.m., administrative assistance (AA)-J stated the licensee had been using a "generic" service plan and was not aware the service plan currently used by the licensee did not meet the assisted living regulation. On April 23, 2026, at 4:36 p.m., licensed assisted	01650			

Minnesota Department of Health

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01650	Continued From page 41 living director (LALD)-A stated the licensee did not list each service, fee for each service or list the person responsible for completing each service on the resident's service plan. LALD-A stated the licensee used the counties customized living tool for all residents who were not private pay. The licensee's Service Plan policy dated December 2008, indicated the Service Plan/Agreement would include: -a specific description of the services and their frequency unique to each client. -the identification of the person or persons or categories of persons who are to provide the service; -the schedule of the RN supervisory visits; -the fee for services provided; and -contingency plan including: 1)The action to be taken by the licensee, the client, or the client's responsible other in the event that scheduled services cannot be provided. Both essential services and non-essential services must be addressed in the contingency plan. 2) The method for the client or the client's other responsible other to contact a representative of the licensee whenever staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730			

Minnesota Department of Health

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01730	Continued From page 42 management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730			

Minnesota Department of Health

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01730	Continued From page 43 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan to include all required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included diabetes type 2, dementia, mood disorder, hypertension (high blood pressure), chronic kidney disease, and hemiplegia (partial loss of one side of the body). R3's record included a Service Plan dated November 30, 2023; however, the service plan lacked a list of services to be provided. On April 22, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's scheduled morning medications. R3's record included comprehensive assessments completed on December 1, 2025,	01730			

Minnesota Department of Health

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01730	Continued From page 44 and February 25, 2026, which indicated R3 required assistance with medications, any controlled medications would be kept under secure storage and nurse would review R3's medications. R3's record lacked an individualized medication management plan to address how R3's medications were being stored, responsible party for ordering R3's medications, identification of medication management tasks that may be delegated to unlicensed personnel, and procedures for notifying registered nurse when a problem arises. On April 23, 2026, at 3:58 p.m., CNS-B stated CNS-B was aware of the required content in a medication management plan and should be in the each resident's assessments completed in Residex (electronic health record). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer	01880			

Minnesota Department of Health

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01880	Continued From page 45 recommended temperatures by failing to monitor and document medication refrigerator temperatures for two of two medication refrigerators. The refrigerators were on both cardinal court (CC), and villa court (VC) units. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 21, 2026 , at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility. CNS-B stated the licensee had two medication refrigerators which are in the locked nurse's office. On April 22, 2026 at 11:50 a.m., the surveyor reviewed the medication refrigerator log with located in the locked nurse's office and observed the internal thermometer temperature reading of 37 degrees Fahrenheit (F). CNS-B stated staff have been instructed to monitor the refrigerator temperatures and keep a recorded temperature log of the medication refrigerator located in the nurse's station. The licensee's temperature log indicated that temps should remain between 35-46 degrees F. The missing temperature logs for refrigerators on CC and VV, for February 2026 are listed below. - February 27, 2026, no documentation of	01880			

Minnesota Department of Health

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01880	Continued From page 46 temperature. VV - February 2,2026, no documentation of temperature CC - February 9,2026, no documentation of temperature CC - February 10,2026, no documentation of temperature CC - February 11, 2026, no documentation of temperature CC - February 17,2026, no documentation of temperature CC - February 22-28, 2026, no documentation of temperature CC On April 21, 2026, at 12:14 p.m., the surveyor reviewed the medication refrigerator content with CNS-B and observed the internal thermometer temperature reading of 37 degrees F and the following medications were being stored: - three unopened insulin pens Lantus Solostar - unopened rectal suppositories The manufacturer's instructions for insulin pens dated August 2022, directed to store Lantus Solostar pens in the refrigerator between 36-46 degrees F. The manufacturer's instructions for rectal suppositories' dated October 2025, directed to store in the refrigerator between 36- 46 degrees F. The licensee's Medication Storage policy dated July 17, 2018, indicated medications managed by the licensee would be securely stored per manufacturer directions and monitored daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880			

Minnesota Department of Health

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01880	Continued From page 47 days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications being stored by the license in two of two medication storage rooms. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on April 21, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility. On April 21, 2026, at 12:01 p.m., the surveyor reviewed Villa Court medication room with CNS-B	01890			

Minnesota Department of Health

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01890	Continued From page 48 and observed the following: -an opened bottle of acetaminophen pain relief expired June 2025. On April 21, 2026, at 12:16 p.m., the surveyor reviewed the Cardinal Court medication storage room with licensed practical nurse (LPN)-I and observed the following; -an opened bottle of facility stock aspirin 81 milligram (mg) (pain relief) expired August 2025; -an opened bottle of vitamin D 25 micrograms (mcg) (supplement) expired August 2025; -two opened bottles of omeprazole 20 mg (decreases stomach acid) expired March 2026; -an opened bottle of vitamin C 50 mg (supplement) expired November 2020; and -an opened bottle of Gingko Bilbao (improves memory) expired November 2025. LPN-I stated anyone who administers medications should be checking the expiration date of the medication before administering. On April 23, 2026, at 4:12 p.m., CNS-B stated the registered nurses (RN)s should be monitoring the medication storage rooms at least monthly looking for expired medications. CNS-B stated the licensee did not have a formal system in place for monitoring medications being stored by the licensee. The licensee's Central Storage of Medications policy dated August 5, 2021, indicated Legend medications that are centrally stored in the nursing office will be kept in their original containers bearing the original prescription label with legible information stating the prescription number, name of the drug, strength and quantity of the drug, expiration date of a time-dated drug, directions for use, the client's name, the prescriber's name, the date of issue, and the	01890			

Minnesota Department of Health

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01890	Continued From page 49 name and address of the dispensing pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge.	01910			

Minnesota Department of Health

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01910	Continued From page 50 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 21, 2026, at 10:35 a.m., LALD-A and CNS-B stated the licensee provided medication management to residents at the facility. The licensee's Discharged Resident/Client Roster Evaluations dated December 1, 2025, through March 23, 2026, indicated R1 was admitted to the facility on September 24, 2025, and discharged on February 7, 2026. R1's diagnoses included epilepsy, chronic pain syndrome, and major depressive disorder. R1's Medication Management Plan: Addendum to Service Plan (service plan) dated September 24, 2025, indicated R1's services included mediation administration. R1's Med (medication) Admin (Administration) Summary dated January 2025, and February 2025, respectively, indicated R1 received the following medications : -Abilify (antidepressant) 2 milligrams (mg) daily; -buspirone HCl (anxiety) 22.5 mg twice daily; -Depakote DR (for seizures) 750 mg three times daily; -Desvenlafaxine ER (antidepressant) 100 mg	01910			

Minnesota Department of Health

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01910	Continued From page 51 daily; -lacosamide (for epilepsy) 200 mg twice daily; -Lamotrigine (for epilepsy) 20 mg twice daily. -Ozempic (for weight loss) 2 mg/3 milliliters (mL) once weekly; -Testosterone Transdermal gel (replacement supplement) 20.25 mg/1.25 grams (gm) two pumps daily; -lorazepam (antianxiety) 0.5 mg twice daily as needed; and -Zofran (antinausea) 4 mg every 8 hours as needed. R1's prescriber orders dated September 29, 2025, included the above noted medications. R1's Discharge Care Plan dated February 7, 2026, indicated R1 moved to a different assisted living facility to be closer to family. R1's Medication Disposition- Date January 28, 2026, included all medications noted above, however, lacked the prescription numbers for Ability, buspirone HCl, Depakote DR, Desvenlafaxine ER, Lamotrigine, Ozempic, Testosterone Transdermal gel, and Zofran. On April 22, 2026 LALD-A and CNS-B further stated R1 had come to the facility with some medications from home and the prescription numbers were not entered into the licensee's electronic medical record system. The licensee's Disposition or Disposal of Medication policy dated May 2, 2025, indicated documentation of the medication destruction would include the prescription number. No further information was provided.	01910			

Minnesota Department of Health

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01910	Continued From page 52 TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Villa Court LLC
1220 VILLA COURT DRIVE
Cromwell, MN 55726
Carlton County
Parcel:

Phone: 218-390-3835
info@villacourtromwell.com

License Info

License: HFID 30721
Sherry Korpi
Risk:
License:
Expires on:
CFPM: Sherry Korpi
CFPM #: 7197; Exp: 12/2/2027

Inspection Info

Report Number: F7983261076
Inspection Type: Full - Single
Date: 4/21/2026 Time: 10:20:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 5-400 Sewage

5-402.11A Priority Level: Priority 1 CFP#: 52

MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.

COMMENT:

AN AIR BREAK WAS PROVIDED FOR BOTH DRAIN LINES FROM THE ICE-MAKING MACHINE WHERE AN AIR GAP IS REQUIRED.

Comply By: 5/5/2026 Originally Issued On: 4/21/2026

Food & Beverage General Comment

- 1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.
- 2) Cheryl Anderson is also a certified food protection manager: CFPM-52217, exp. 3/27/28.
- 3) Provided an illness log.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F7983261076 from 4/21/2026

Sherry Korpi
Head Cook


Gary Collyard,
Public Health Sanitarian 3
218-302-6147
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Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Page: 1

Establishment Info

Villa Court LLC
Cromwell
County/Group: Carlton County

Inspection Info

Report Number: F7983261076
Inspection Type: Full
Date: 4/21/2026
Time: 10:20:00 AM

Food Temperature: **Product/Item/Unit:** Foods Frozen; **Temperature Process:** Cold-Holding

Location: Walk-In Freezer at -5 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Tuna Salad; **Temperature Process:** Cold-Holding

Location: Walk-In Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Chicken Breasts; **Temperature Process:** Cooking

Location: Oven at 186 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Chicken Wings; **Temperature Process:** Cooking

Location: Oven at 190 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Cheesy Potatoes; **Temperature Process:** Cooking

Location: Oven at 200 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Wash Water; **Temperature Process:** Warewashing

Location: Warewashing Machine at 162 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Rinse Water; **Temperature Process:** Warewashing

Location: Warewashing Machine at 180 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Utensil Surface; **Temperature Process:** Warewashing

Location: Warewashing Machine at 160 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

Page: 1

Establishment Info

Villa Court LLC
Cromwell
County/Group: Carlton County

Inspection Info

Report Number: F7983261076
Inspection Type: Full
Date: 4/21/2026
Time: 10:20:00 AM

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Dispenser
Location: Three-Compartment sink **Equal To** 704 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30721016-0	Date: April 21, 2026
Facility Name: Villa Court LLC	
Facility Address: 1220 Villa Court Drive, Cromwell, MN 55726	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments:

- The door closer had been disconnected from the labeled fire door for the employee lounge.
 - Labeled fire doors for resident rooms 102, 105, 111, 113, and G12 in the Cardinal Court building were held open with wedges or other devices. These rooms were unoccupied during the tour.
- Fire doors shall be maintained to contain fire and smoke in the event of an emergency.*

3. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: During the building tour of the old wing, the surveyor asked maintenance manager (MM)-D if a remote button or switch was installed that would disengage the controlled egress locking system for the exit door with the keypad on the back side of the building. MM-D stated no and explained they were not aware of this requirement.

- Unlocking procedures for this controlled egress locked door were not included with the fire safety and evacuation plan.

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

Comments: Extension cords were used to supply power in the old wing common area living room, and in resident rooms 47 and 49.

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

Comments: Carbon monoxide detectors were not installed within ten feet of all bedrooms. Maintenance manager (MM)-D explained a carbon monoxide detection system was installed in the mechanical rooms. MM-D verified carbon monoxide detectors were not installed elsewhere in the building where carbon monoxide producing equipment and a gas fireplace were installed.

6. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3]

Comments: Two small oxygen cylinders were stored on the floor in resident room 38 and several small oxygen cylinders were stored on the top of a shelving unit in the oxygen storage room. These oxygen cylinders were not stored securely in racks or holders.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- *Electrical wires and electrical conduit were hanging in the maintenance shop in the old wing of the building. Maintenance manager (MM)-D stated the facility was already working with a licensed electrician to make the needed corrections.*
- *The med room ceiling was in disrepair in the old wing of the building.*
- *In the shared bathroom for resident room 38, laminate was missing from the edges of the sink vanity countertop.*
- *In the shared bathroom for resident room 47, the laminate on the sink vanity countertop was chipped, and tile was missing from a small area on the floor.*

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The fire safety and evacuation plan (FSEP) was stored in a red fire plan binder. The FSEP lacked evacuation procedures for the individualized unique needs of residents. Individualized resident evacuation procedures had been developed but were not included with the FSEP.

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

Comments: The surveyor requested records for employee fire safety and evacuation plan training completed between April 2025 and April 2026, from the licensee. Record review of the available documentation indicated all employees completed FSEP training on January 28, 2026. Documentation was not provided to support employee training on the FSEP was completed at the required frequency of twice per year.

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

Comments: The surveyor requested records for evacuation drills completed between April 2025 and April 2026, from the licensee. Record review of the provided fire drill reports indicated fire drills had not been conducted in the last year. The most recent fire drill report, dated February 17, 2025, had inappropriately combined all shifts for this drill. Maintenance manager (MM)-C stated a former employee had been responsible for evacuation drills and no additional records could be located.