



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

January 21, 2026

Licensee

Living Hope Homes Cardinal Crest
2310 St Germain Street West
Saint Cloud, MN 56301

RE: Initial License Number 420049
Health Facility Identification Number (HFID) 41625
Project Number SL41625015

Dear Licensee:

On December 30, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed November 3, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 21, 2026.

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 FOLLOW UP SURVEY INITIAL COMMENTS SL41625015-1 On December 29, 2025, through December 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 3, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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	
{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health
STATE FORM 6899 ROYZ12 If continuation sheet 3 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(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
{0 680}	Continued From page 3	{0 680}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:				
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable	{0 700}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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	
{0 700}	Continued From page 4 relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}	Not reviewed during this survey.		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	{0 730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 730}	Continued From page 5 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	{01620}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 6 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse 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	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 7 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	{01640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
{01640}	Continued From page 8 This MN Requirement is not met as evidenced by:		{01640}	Not reviewed during this survey.	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:		{01760}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:		{01880}		
				Not reviewed during this survey.	

Minnesota Department of Health
STATE FORM 6899 ROYZ12 If continuation sheet 10 of 10



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

December 12, 2025

Licensee

Living Hope Homes - Cardinal Crest
2310 St Germain Street West
Saint Cloud, MN 56301

RE: Provisional Conditional License Number 420049
Health Facility Identification Number (HFID) 41625
Project Number(s) SL41625015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 3, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **March 12, 2025**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$2,000.00. **MDH is not imposing these fines against your provisional license at this time.**

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Living Hope Homes - Cardinal Crest a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Living Hope Homes - Cardinal

Crest is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. No new admissions:** Living Hope Homes - Cardinal Crest will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Living Hope Homes - Cardinal Crest must provide the Department:
 - i. A list of the names and birthdates of any individuals Living Hope Homes - Cardinal Crest is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Living Hope Homes - Cardinal Crest to correct the violations cited during the survey as well as to determine the overall practice of Living Hope Homes - Cardinal Crest in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- d. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- e. Corrective Action Plan:** Living Hope Homes - Cardinal Crest will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

- i. A statement of the concern
- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Living Hope Homes - Cardinal Crest is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Living Hope Homes - Cardinal Crest is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Living Hope Homes - Cardinal Crest. If MDH determines Living Hope Homes - Cardinal Crest is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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 Kelly Thorson directly at: 320-223-7336 or email at: Kelly.Thorson@state.mn.us.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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: SL41625015-0 On November 3, 2025, through November 6, 2025, 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 five residents; all of whom were receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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	
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(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
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by two of three employees (unlicensed personnel (ULP)-B and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 510	Continued From page 4 ULP-B began working for the licensee, providing direct cares to the residents on September 21, 2025. On November 4, 2025, from 7:44 a.m., through 8:14 a.m., surveyor observed ULP-B administer medication and provide blood glucose monitoring for R2. ULP-B unlocked the medication cart and stated, "I don't have any hand sanitizer, normally I would put on hand sanitizer before gloves." Without preforming hand hygiene, ULP-B donned gloves and grabbed supplies for blood glucose monitoring. ULP-B obtained R2's blood glucose and removed gloves. Without performing hand hygiene ULP-B donned new gloves and stated, "Again normally I would use hand sanitizer or wash my hands." With clean gloves ULP-B removed the testing strip and discarded it. ULP-B did not clean up the spilled blood on the medication passing tray. ULP-B then doffed gloves and washed hands. ULP-B then dosed up R2's medication and administered it to R2. R2 dropped one of the medications onto the floor, ULP-B picked it up with bare hands and stated, "Now I don't know what to do when this happens, I have never had this happen before." ULP-B handed the pill back to R2 and R2 stated, "There is a five-minute rule." ULP stated, "Now again I am not sure what we do here normally I was told you don't have them take that pill and you pop a new one, but I don't know what they do here." Then ULP-B looked at the resident and asked, "Do you want me to get a new one or do you want to just take that one?" R2 stated, "I will take it." R2 placed the pill into her mouth before surveyor could stop her. On November 4, 2025, at 1:02 p.m., ULP-B stated, "We should always wash our hands or use	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 510	Continued From page 5 hand sanitizer when our hands are dirty or after helping a resident." ULP-G began working for the licensee, providing direct cares to the residents on February 27, 2025. On November 5, 2025, at 7:20 a.m., surveyor observed ULP-G go into R5's room without preforming hand hygiene, ULP-G assisted R5 with dressing and bilateral orthotic braces. Then without performing hand hygiene ULP-G escorted R5 to the dining room and started to prepare breakfast for all of the residents. At 7:52 ULP-G preformed hand hygiene. On November 5, 2025, at 7:57 a.m., surveyor observed ULP-G prepare medications for R6 without preforming hand hygiene. ULP-G administered R6 omeprazole 40 milligrams, and R6 dropped it on the floor. ULP-G picked it up and handed it to R6 to take. Without preforming hand hygiene ULP-G returned to the kitchen to continue cooking breakfast for the residents. On November 5, 2025, at 8:10 a.m., ULP-G stated, "I was trained that as long as [the pills] not lost or dirty we just make sure the resident still takes it." On November 5, 2025, at 8:13 a.m., ULP-G stated, "We are supposed to wash our hands in between helping people and if our hands look dirty. I may have forgotten in my rush this morning, but I normally do." On November 5, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-D acknowledged staff should wash their hands after changing gloves and stated, "I have a specific part of the slide show	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 510	Continued From page 6 that goes through different examples like if your hands are visible soiled you should wash hands and appropriate times for hand sanitizer like before each med pass. Sometimes even if your hands are not visibly soiled like when feeding a resident or brief changes." The licensee's 8.09 Hand washing policy dated, August 1, 2021, indicated, "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: - Before, during, and after preparing food - Before eating food - Before and after caring for someone who is sick - Before and after treating a cut or wound - After using the toilet - After changing diapers or cleaning up after someone who has used the toilet - After blowing your nose, coughing, or sneezing - After touching an animal or animal waste - After handling pet food or pet treats - After touching garbage" The licensee's 8.07 Gloves policy dated, August 1, 2021, indicated, "Gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. PROCEDURE: 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping the cuff of one glove and pulling it off, turning it inside out. With an ungloved hand tuck finger inside the cuff of the remaining glove and pull off, turning inside out. 6. Dispose used gloves in the proper receptacle. 7. Rewash hands."	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 510	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 680	Continued From page 8 content. 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: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Must identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. - Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On November 5, 2025. at 12:30 p.m., licensed	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 680	Continued From page 9 assisted living director (LALD)-C acknowledged the items were missing in the EP plan and stated, "We do not have the patient population in there, and it wasn't dated, the engineer pointed that out and that is why I took the binder home to try to get those corrected but no we don't have those, and so far we have only done fire drills we have not done any other drills since opening yet." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all resident's (R) personal health and medical information was kept private. 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	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 700	Continued From page 10 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 4, 2025, from 11:20 a.m., to 11:25 a.m., surveyor observed unlicensed personnel (ULP)-B walk away from the charting computer to attend to other tasks in another area of the facility. The computer screen was left open displaying R2's medical information. The surveyor observed two residents in the common area where the computer was left open and accessible. On November 4, 2025, at 11:31 a.m., ULP-B acknowledged the computer had been left open with R2's medical records accessible and stated, "Anything that shows the residents information nobody should see it, I should put [the computer screen] down. I should have closed it before walking away." On November 4, 2025, from 11:50 a.m., to 11:53 a.m., surveyor observed ULP-B walk away from the medication cart while the computer screen was left open displaying R2's medical information. On November 5, 2025, from 8:01 a.m., to 8:05 a.m., surveyor observed ULP-G walk away from the medication cart while the computer screen was left open displaying medical information for all five residents. The screen was left on while there were two residents in the common area and remained on until the computer screen timed out and the screen went black. On November 5, 2025, at 8:11 a.m., ULP-G stated, "We are supposed to close it as soon as	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
0 700	Continued From page 11 we walk away, I always try to make sure the laptop is closed enough that it won't lock me out." On November 5, 2025, at 9:30 a.m., licensed assisted living director (LALD)-C stated, "If they are working on a laptop, they should be making sure that they are locking the screen anytime that they walk away." The licensee's 5.02 Competency Training Evaluations policy, dated August 1, 2021, indicated, prior to the delegation of services they must make certain the unlicensed personnel is trained in areas to include awareness of confidentiality and privacy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 12 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure the resident record included accurate documentation of all provided services for one of two (R2) with records reviewed. This practice resulted in a level two violation (a	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted and began receiving assisted living services on March 17, 2025. R2's record included a Residency Agreement signed by R2 on March 17, 2025. On November 4, 2025, at 7:44 a.m., surveyor observed unlicensed personnel (ULP)-B provide blood sugar monitoring to R2. R2's signed Service Plan, dated June 11, 2025, indicated R2's services included ambulation, bathing reminders, deep room clean, AM/PM dressing, grooming, laundry, linen change, meal reminder, medication administration, vital signs, oxygen delivery, toileting reminders, and blood glucose monitoring three times a day. R2's Service Recap Summary - Monthly form dated, October 1, 2025, through October 31, 2025, indicated R2 received safety checks daily at 6:00 a.m., nail care once a week in the AM, daily weight in the AM, oxygen management daily at 8:00 a.m., wound care daily, and 12:00 p.m., supervision of oxygen delivery once a week, and supervision of blood glucose record once a week. R2's Service Recap Summary - Monthly form lacked documentation of safety checks daily at 6:00 a.m., on October 12, 2025, and October 30,	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 14 2025, nail care once a week in the AM on October 7, 2025, daily weight in the AM on October 21, 2025,, oxygen management daily at 8:00 a.m., on October 8, 2025, and 12:00 p.m., wound care daily on October 8-10, 2025, supervision of oxygen delivery once a week on October 7, 2025, and on October 14, 2025,, and supervision of blood glucose record once a week on October 7, 2025. On November 5, 2025, at 9:34 a.m., clinical nurse supervisor (CNS)-D stated, "Documentation is done right away, so if I prepare it in a cup, I administer medication to the resident and confirm it then I document it was complete. If it says set up, then you can document that, but you can't document that it was administered until the resident takes it. Same with services, you document as soon as you finish doing it, if you don't document it, then it wasn't done. I never train it any other way because if they say they are going to do it never actually gets done." The licensee's 2.37 Resident Record - Documentation policy dated, August 1, 2021, indicated, "1. Staff providing assisted living services will document daily medications, services, treatments, or therapies provided to residents. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. 3. For medications administered or treatments and/or therapies administered, documentation in a resident ' s chart must include the date and time of the administration. 4. When medications, services, treatments, or therapies are not performed per the service agreement and schedule, staff must document the reason why it	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 15 was not performed or administered. 5. Tasks not performed or administered must be reported and followed up on to meet the resident ' s needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 3, 2025, between 11:30 a.m. and 12:30 p.m. with the licensed assisted living director (LALD)-C, the surveyor	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(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
0 775	Continued From page 16 observed the following conditions: CIGARETTE BUTTS DISPOSAL: The surveyor observed that many cigarette butts on the ground in front of the facility and a combustible receptacle for the cigarette butts and ashes was in a pile of leaves on the patio. An approved receptacle shall be provided for the disposal of the cigarette butts/ashes on the patio and the butts shall be disposed of in the receptacle. OXYGEN CYLINDERS: The surveyor observed an oxygen cylinder unsecured in the closet at the end of the corridor. All oxygen cylinders shall be secured. The deficient conditions were visually verified by LALD-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 17 section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for three of twenty employees (registered nurse (RN)-A, unlicensed personnel (ULP)-E, ULP-F). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 3, 2025, at 10:45 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated all shifts were scheduled with one ULP working. On November 3, 2025, at 12:32 p.m., LALD-C provided the surveyor with the facility NETStudy 2.0 roster. RN-A	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 18 RN-A was hired on April 1, 2024, to provide direct care services to the licensee's residents. RN-A was licensed by the Minnesota Board of Nursing on May 22, 2013. On November 3, 2025, at 1:05 p.m., LALD-C stated RN-A is a triage nurse and would come into the facility if the need arose when on-call and would have direct contact with residents. RN-A's employee record lacked evidence the licensee submitted a background study for RN-A under the current assisted living license and affiliated to the licensee's HFID number. ULP-E ULP-E was hired on May 11, 2025, to perform direct care services to the licensee's residents. ULP-E's employee record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the licensee's HFID number. ULP-F ULP-F was hired on September 25, 2024, to perform direct care services to the licensee's residents. ULP-F's employee record lacked evidence the licensee submitted a background study for ULP-F under the current assisted living license and affiliated to the licensee's HFID number. On November 3, 2025, at 1:35 p.m., LALD-C sent the surveyor an email that indicated, "backgrounds for: [ULP-F] - was not completed, when I looked for her for any of our sites it says she was removed from our roster for some reason. She is casual and not scheduled for any	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 19 shifts coming up. I will have to rerun hers. [ULP-E] - was not completed- is now completed [RN-A] - was not completed- is now completed" On November 3, 2025, at 2:43 p.m., LALD-C provided the surveyor with a shift schedule dated June 29, 2025, through July 10, 2025, which indicated ULP-F worked for the licensee on July 2, 2025. LALD-C also provided the surveyor with a shift schedule dated October 19, 2025, through November 2, 2025, which indicated ULP-F worked for the licensee on November 2, 2025. The licensee's 4.02 Background Studies policy, dated August 1, 2021, indicated, "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 20 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(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 21 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for one of two 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 was admitted and began receiving assisted living services on April 22, 2025. R3's record included a Residency Agreement signed by R3's on April 22, 2025. R3's record included an Admission Assessments dated April 18, 2025, and 14-day assessment dated May 5, 2025, which indicated 17 days had passed since R3's initial assessment. On November 6, 2025, at 10:10 a.m., licensed assisted living director (LALD)-C acknowledged the assessments were done more than 14 days apart and stated, "I don't have an answer for you as to why it is late, I see the admission assessment for the 18th, but he didn't admit until	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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 22 the 22nd, and that nurse isn't even here anymore so I can't ask her." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
01640	Continued From page 23 by the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted and began receiving assisted living services on March 17, 2025. R2's record included a Residency Agreement signed by R2's on March 17, 2025. On November 4, 2025, at 7:44 a.m., surveyor observed unlicensed personnel (ULP)-B provide blood sugar monitoring to R2. R2's Individualized Treatment and Therapy Plan dated as of November 3, 2025, included blood glucose monitoring four times per day. R2's Treatment Recap Summary - Monthly form dated, October 1, 2025, through October 31, 2025, indicated R2 received blood glucose monitoring 4 times a day. R2's signed Service Plan, dated June 11, 2025, indicated R2's services included ambulation, bathing reminders, deep room clean, AM/PM dressing, grooming, laundry, linen change, meal	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
01640	Continued From page 24 reminder, medication administration, vital signs, oxygen delivery, toileting reminders, and blood glucose monitoring three times a day. On November 4, 2025, at 12:10 p.m. clinical nurse supervisor (CNS)-d stated, "[R2's] updated orders when she came back from the hospital changed to 4 times a day for blood glucose monitoring and we should have updated it then. It was missed but we had her sign a new one today. The licensee's 6.08 Service Plan policy dated, August 1, 2021, indicated, "2. The service plan and any revisions shall include a signature or other authentication by [Licensee] and by the resident, or resident ' s representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring. 4. Services plans shall include fees for the services indicated in the service plan. 5. [Licensee] shall provide information to the residents about any changes to the facility ' s fees for assisted living services, included with a change in fees is information how to contact the Office of Ombudsman for Long Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
01760	Continued From page 25 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication administration was documented accurately in the electronic medication administration record (EMAR) for one of three residents (R2) reviewed for medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted and began receiving assisted living services on March 17, 2025. R2's record included a Residency Agreement signed by R2's on March 17, 2025. R2's signed Service Plan, dated June 11, 2025, indicated R2's services included ambulation,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
01760	Continued From page 26 bathing reminders, deep room clean, AM/PM dressing, grooming, laundry, linen change, meal reminder, medication administration, vital signs, oxygen delivery, and toileting reminders. R2's provider orders signed September 24, 2025, included Mupirocin external ointment 2 percent (%) apply to arms/ abdomen topically two times a day for wound care. On November 4, 2025, from 7:44 a.m., through 8:14 a.m., surveyor observed unlicensed personnel (ULP)-B administer medications to R2. ULP-B dosed up all of R2's morning medications which included Mupirocin external ointment 2%, ULP-B administered all of R2's medication except the Mupirocin external ointment 2%. R2 requested to wait on applying the ointment until after R2's bath that would happen later in the shift. ULP-B agreed and placed the ointment back in the medication cart. ULP-B then entered into the EMAR that all medications including the Mupirocin external ointment 2% had been administered. Surveyor checked back at the end of the shift and R2 had not received the ointment. ULP-B did not change the charting in the EMAR by the end of survey on November 6, 2025. On November 4, 2025, at 1:00 p.m., ULP-B stated, "I marked that it was administered because I was planning to administer it, but she wanted to wait until after her bath, so this way I won't have to go back and chart it late. We should always chart things as we do them, but we also don't want to chart things late." On November 5, 2025, at 9:34 a.m., clinical nurse supervisor (CNS)-D stated, "Documentation is done right away, so if I prepare it in a cup, I administer medication to the resident and confirm	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(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
01760	Continued From page 27 it then I document it was complete. If it says set up, then you can document that, but you can't document that it was administered until the resident takes it. Same with services, you document as soon as you finish doing it, if you don't document it, then it wasn't done. I never train it any other way because if they say they are going to do it never actually gets done." The licensee's 7.08 Medication Management - Administration & Setup policy dated, August 1, 2021, indicated, "Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This practice resulted in a level two violation (a	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 28 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 5, 2025, at 7:20 a.m., surveyor observed unlicensed personnel (ULP)-G with resident (R)2 in the dining room administering medications to R2, which included R2's inhaler. ULP-G left R2 unattended to finish an unknown amount of medication and the inhaler and went to R5's room. At 7:45 a.m., surveyor observed ULP-G to re-enter the dining room and place R2's inhaler into the medication cart. ULP-G failed to lock the medication cart and left to perform tasks in another area of the facility. At 7:59 a.m., ULP-G locked the medication cart. On November 5, 2025, at 8:00 a.m., ULP-G stated, "Med carts should be locked when we walk away from them, I was trying to get the med to her on time but that was no excuse." On November 5, 2025, at 9:27 a.m., licensed assisted living director (LALD)-C stated, "Unless they have that self-administration order everything has to be locked so PRNs are kept in the med room, which is locked, narcotics are double locked and regular meds are in the med cart and that is always locked. Anything that we receive from the pharmacy is locked up. That is what the staff are trained to do." The licensee's 7.11 Medication Storage policy	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 29 dated, August 1, 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer ' s directions. Only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R2) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
02310	Continued From page 30 The findings include: On November 3, 2025, at 12:19 p.m., during the facility tour, the evaluator observed one unsecured oxygen cylinder standing upright on the floor and not secured to prevent tipping in the locked medication closet. Licensed assisted living director (LALD)-C asked another staff member to get the tank secured and stated, "The oxygen tanks should always be secured so staff are already taking care of that." Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. The licensee's 7.40 Oxygen policy dated, August 1, 2021, indicated, "Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location." The policy did not specifically address properly securing oxygen cylinders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
03090 SS=F	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES CARDINAL CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 ST GERMAIN ST W SAINT CLOUD, MN 56301			
(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
03090	Continued From page 31 subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 3, 2025, at 12:13 p.m., surveyor observed the entrance way and front door with no electronic monitoring sign. On November 4, 2025, at 8:31 licensed assisted living director (LALD)-C acknowledged there was no electronic monitoring sign and stated, "Looks like someone has been removing things, thank you for pointing that out, I will get that fixed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03090			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

LIVING HOPE HOMES CARDINAL CRE
2310 ST GERMAIN ST W
St Cloud, MN 56301
Stearns County
Parcel:

Phone:

License Info

License: HFID 41625

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

Inspection Info

Report Number: F1046251139
Inspection Type: Full - Single
Date: 11/3/2025 Time: 11:00:34 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery:

New Order: 2-100 Supervision

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

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

COMMENT: THERE IS NO CFPM EMPLOYED AT THIS ESTABLISHMENT. SEND ONE FULL TIME EMPLOYEE TO A FOOD SAFETY COURSE AND APPLY FOR STATE CERTIFICATE AFTER COURSE COMPLETION.

Comply By: 11/3/2025 Originally Issued On: 11/3/2025

New Order: 2-100 Supervision

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

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: POST THE CFPM CERTIFICATE ONCE RECEIVED.

Comply By: 12/1/2025 Originally Issued On: 11/3/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED EGGS STORED ABOVE CUT LETTUCE AND OTHER VEGETABLES IN THE UPRIGHT COOLER. DISCONTINUE STORING RAW SHELL EGGS ABOVE READY-TO-EAT FOOD ITEMS.

Comply By: 11/3/2025 Originally Issued On: 11/3/2025

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: FOODS IN THE UPRIGHT COOLER MEASURED: FRENCH ONION DIP (43), YOGURT (45), MILK (44). MAINTAIN ALL TCS FOOD ITEMS AT 41 OR BELOW.

Comply By: 11/3/2025 Originally Issued On: 11/3/2025

New Order: 4-300 Equipment Numbers and Capacities

4-301.11 Priority Level: Priority 2 CFP#: 33

MN Rule 4626.0675 Provide equipment in sufficient number and capacity for cooling, heating, hot and cold holding of food to maintain foods at proper temperatures.

COMMENT: UPRIGHT COOLER WAS OVERFILED WITH FOOD ITEMS, NOT ALLOWING FOR PROPER AIR CIRCULATION. TCS FOOD ITEMS IN THE UPRIGHT COOLER MEASURED 43-45F. PROVIDE AN ADDITIONAL UPRIGHT COOLER TO STORE FOODS PROPERLY.

Comply By: 12/1/2025 Originally Issued On: 11/3/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

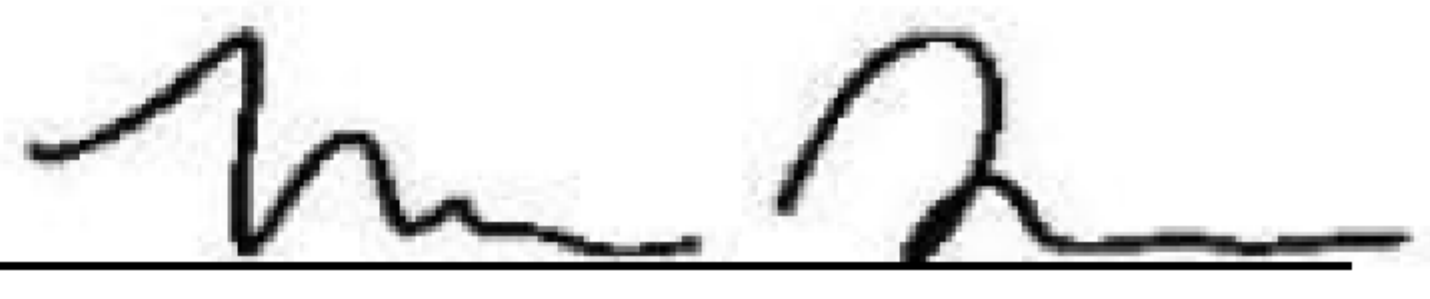
COMMENT: ESTABLISHMENT USES QUAT SANITIZER, PROVIDE QUAT TEST STRIPS TO MEASURE SANITIZER CONCENTRATION.

Comply By: 11/10/2025 Originally Issued On: 11/3/2025

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 St Cloud District Office inspection report number F1046251139 from 11/3/2025

Establishment Representative



Nicole Larrison,
Public Health Sanitarian 1
320-640-3534
nicole.larrison@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

LIVING HOPE HOMES CARDINAL CRE
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046251139
Inspection Type: Full
Date: 11/3/2025
Time: 11:00:34 AM

Food Temperature: **Product/Item/Unit:** FRENCH ONION DIP; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 43 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: Upright Cooler at 45 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: Upright Cooler at 44 Degrees F.

Comment:

Violation Issued?: Yes



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Page: 1

Establishment Info

LIVING HOPE HOMES CARDINAL CRE
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046251139
Inspection Type: Full
Date: 11/3/2025
Time: 11:00:34 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Pre-Soaked Towelettes

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1046251139		Food Establishment Inspection Report		Page 1 of 1	
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		3	Date: 11/3/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:00:34 AM
		Score (optional)			Dur: min
Establishment: LIVING HOPE HOMES CARDINAL CRE		Address: 2310 ST GERMAIN ST W		City/State: St Cloud, MN	Zip: 56301
License/Permit #: HFID 41625		Permit Holder:		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	OUT	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	N/A	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	OUT	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food			
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Safe Food and Water					
30	N/A	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	N/A	Variance obtained for specialized processing methods			
Food Temperature Control					
33	X	Proper cooling methods used; adequate equipment for temperature control			
34	N/O	Plant food properly cooked for hot holding			
35	N/O	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature)					
Follow-up: Follow-up Date:					
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury					