Electronically Delivered

May 14, 2026

Licensee
Poplar Meadows of McIntosh
325 Scots Avenue Southeast
McIntosh, MN 56556

RE: Project Number(s) SL30294016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

(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: SL30294016-0 On April 20, 2026, through April 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 25 residents; 25 receiving services under the Assisted Living Facility license. An immediate correction order was identified on April 21, 2026, issued for SL30294016-0, tag identification 1290. The licensee took action on April 21, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of 32 residents, with a current census of 25 residents. During the entrance conference on April 20, 2026, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Direct Care Staffing Plan dated June 23, 2025, indicated CNS-B and LALD-A had developed and implemented the written staffing plan, however, the Direct Care Staffing Plan lacked documentation, which indicated the staffing plan had been reviewed at least twice per year. On April 22, 2026, at 10:39 a.m., LALD-A stated LALD-A and CNS-B discussed the staffing plan every few months, however, did not document the review of the staffing plan. LALD-A further stated LALD-A and CNS-B had documented review of the staffing plan on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 21, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 5 Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 485		

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0 485	Continued From page 6 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. LALD-A further stated the licensee's basic service package included two meals per day with an additional third meal offered for an additional charge. On page five of the undated Assisted Living Housing and Services Contract, Section Assisted Living Service-Service Plan indicated residents are required to pay for the Assisted Living Service Package in addition to the monthly housing rent. A description of what is included in the service packages is attached and part of this Assist Living and Housing Contract is the (licensee name) Assisted Living Rental Rate and Service Price Sheet [sic]. On page one of the Service Plan, section Meals and Snacks indicated two meals included in package (package all residents must purchase) with an extra meal offered for an additional charge. Resident assisted living contracts with the service plan addendum lacked an option for residents to opt out of payment for two or three meals residents would not want. On April 22, 2026, at 10:41 a.m., LALD-A stated	0 485		

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0 485	Continued From page 7 all residents were required to purchase two meals per day as part of the licensee's basic service package and receive a third meal per day for an additional charge. LALD-A further stated LALD-A was not aware the licensee could not include and charge for meals as part of the resident's assisted living contract. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated April 17, 2026, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a TB screening and a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-J , registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 20, 2026, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on July 16, 2025, and the facility was determined to be a low risk level. ULP-J ULP-J was hired on June 6, 2018, to provide direct care services to residents at the assisted	0 660		

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0 660	Continued From page 9 living facility. On April 21, 2026, at 7:36 a.m., the surveyor observed ULP-J administer R4's scheduled morning medication. ULP-J's employee record contained a TST administered at 10:18 a.m., on June 27, 2018, however, the TST lacked documentation of when the TST was read. ULP-J's employee record lacked evidence of a TB screen and a two-step TST or other evidence of a TB screening, such as a blood draw, within 90 days of employment or upon hire. RN-C RN-C was hired on April 30, 2024, to provide direct care services to residents and supervision to the staff at the assisted living facility. Throughout the survey April 20, 2026, through April 22, 2026, the surveyor observed RN-C provide direct care to residents at the assisted living facility. RN-C's employee record contained a negative Baseline TB Screening Tool for Health Care Workers (HCWs) dated April 29, 2024. In addition, RN-C's record contained a negative QuantiFERON TB Gold blood test collected on September 18, 2019 (1,686 days prior to RN-C's employment start date). RN-C's employee record lacked evidence of a two-step TST or other evidence of a TB screening, such as a blood draw, within 90 days of employment or upon hire. On April 22, 2026, at 10:50 a.m., LALD-A stated	0 660		

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0 660	Continued From page 10 the licensee accepted two step TSTs or a TB blood draw within 90 days of an employee's start date or would have the employee go to the clinic for a TB blood draw. LALD-A further stated RN-C's TB blood draw was over 90 days old from RN-C's employment start date. LALD-A stated ULP-J's employee record did not have documentation of the first TST reading or a second TST administration and LALD-A had thought ULP-J completed the two step TST process. The licensee's 8.16 TB Screening policy dated August 1, 2021, indicated new staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. New staff will have an IGRA (Interferon-Gamma Release Assay) blood test or a two-step Mantoux (TST) conducted with results document on the Baseline TB Screening Tool for HCWs. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated April 17, 2026, indicated a licensee could accept a TST or IGRA blood test dated within 90 days of hire for a new employee.	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=E	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 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	0 730		

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	30294	A. BUILDING: _____ B. WING _____	04/22/2026

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0 730	Continued From page 12 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 observation, interview, and record review, the licensee failed to ensure resident records included documentation of the registered nurse (RN) face-to-face medication management reassessments for two of three residents (R6, R7) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 20, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B	0 730		

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0 730	Continued From page 13 stated the licensee provided medication management to residents at the facility. R6 R6's diagnoses included chronic kidney disease and depression. R6's Service Plan dated December 29, 2022, indicated R6 received medication assessment and setup, however, lacked medication administration by unlicensed personnel (ULPs). R6's prescriber orders dated April 1, 2026, included an order for an antianxiety medication. In addition, R6 self-managed and self-administered all other oral medications. On April 21, 2026, at 7:06 a.m., the surveyor observed ULP-I administer R6's scheduled morning medication. R6's Individualized Medication Management Plan Sample Form [sic] dated April 1, 2025, included a medication reassessment. R7 R7's diagnoses included benign prostatic hyperplasia (BPH- noncancerous enlargement of the prostate gland) and depression. R7's Service Plan dated December 29, 2022, indicated R7 received medication assessment, setup, and medication administration by ULPs. R7's prescriber orders dated September 19, 2025, included two supplements, two antidepressants, and two medications to treat BPH. On April 21, 2026, at 8:45 a.m., the surveyor	0 730		

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0 730	Continued From page 14 observed ULP-I administer R7's scheduled morning medications. R7's Individualized Medication Management Plan Sample Form [sic] dated June 11, 2024, included a medication reassessment. R6 and R7's records did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On April 22, 2026, at 11:13 a.m., CNS-B stated CNS-B did not document an annual face-to-face medication reassessment for R6 or R7, however, CNS-B stated CNS-B had completed annual face-to-face medication reassessments with the resident's annual assessment. The licensee's 7.01 Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated a medication management assessment would be conducted face-to-face with the resident by the RN. The assessment must include an identification and review of all medications the resident is known to be taking. The assessment must include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. The assessment must identify interventions needed in management of medications to prevent diversion. In addition, (licensee name) will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be	0 730		

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0 730	Continued From page 15 medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April, 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for four of nine employees (unlicensed personnel (ULP)-E, ULP/cook (C)-F, ULP-G, ULP-H). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was	01290		

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01290	Continued From page 17 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on April 21, 2026. During the entrance conference on April 20, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-E ULP-E was hired on July 20, 2020, and effective August 1, 2021, began to provide direct assisted living services to residents. The licensee's April 2026 schedule indicated ULP-E had worked 10- 12-hour night shifts from April 1, 2026, through April 19, 2026. On April 21, 2026, at 5:47 a.m., ULP-F let the surveyor into the facility. ULP-F and ULP/C-F were the only staff present in the building. ULP-F stated ULP-F had worked the twelve-hour night shift alone. The licensee's NETStudy 2.0 Roster dated April 20, 2026, indicated ULP-E's employee background study was Eligible- COVID-19-Study- Expired on December 31, 2022. ULP/C-F ULP/C-F was hired on July 14, 2015, and effective August 1, 2021, began to provide direct assisted living services and cooking for residents.	01290		

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01290	Continued From page 18 On April 21, 2026, at 5:47 a.m., the surveyor entered the facility and observed ULP/C-F unsupervised in the hallway. ULP/C-F and ULP-E were the only staff present in the building. On April 21, 2026, at 7:20 a.m., ULP/C-F stated ULP/C-F's job duties were primarily cooking for residents, however, ULP/C-F was trained to fill in as a ULP for emergencies. The licensee's NETStudy 2.0 Roster dated April 20, 2026, indicated ULP-F's employee background study was Disqualified- Set Aside- COVID-19- Study- Expired on December 31, 2022. ULP-G ULP-G was hired on October 19, 2011, and effective August 1, 2021, began to provide direct assisted living services to residents. The licensee's April 2026 schedule indicated ULP-G had worked six 12-hour day shifts from April 1, 2026, through April 19, 2026. The licensee's NETStudy 2.0 Roster dated April 20, 2026, indicated ULP-G's employee background study was Eligible- COVID-19- Study- Expired on December 31, 2022. ULP-H ULP-H was hired on November 8, 2011, and effective August 1, 2021, began to provide direct assisted living services to residents. The licensee's April 2026 schedule indicated ULP-G had worked five 12-hour day shifts from April 1, 2026, through April 19, 2026. The licensee's NETStudy 2.0 Roster dated April	01290		

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01290	Continued From page 19 20, 2026, indicated ULP-H's employee background study was Eligible- COVID-19-Study- Expired on December 31, 2022. ULP-E, ULP/C-F, ULP-G, and ULP-H's employee records lacked a cleared background study through the Minnesota Department of Human Services (MN DHS) NETStudy 2.0 website. On April 20, 2026, at 11:52 a.m., LALD-A stated LALD-A was responsible for completing employee background checks on the MN DHS NETStudy 2.0 website. On April 21, 2026, from 9:01 a.m., through 9:21 a.m., the surveyor reviewed the licensee's NETStudy 2.0 Roster with LALD-A. LALD-A stated ULP-E, ULP/C-F, ULP-G, and ULP-H were current employees of the licensee and worked unsupervised. LALD-A further stated in 2021, LALD-A completed new background studies on all employees under the licensee's assisted living healthcare facility identification number (HFID) since the licensee would no longer hold a comprehensive license. LALD-A stated LALD-A was unable to access the licensee's previous comprehensive NETStudy 2.0 Roster and LALD-A was not aware some of the employee's background studies were listed as COVID-19 studies and expired. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated (licensee name) will initiate a background study on all employees using the MN DHS NetStudy online program [sic]. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records will include documentation of a completed criminal background study.	01290		

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01290	Continued From page 20 The MN DHS Background Studies website last updated March 30, 2026, indicated "DHS temporarily modified background studies during COVID-19, but modifications ended January 1, 2023, and emergency studies are no longer valid." Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01640	Continued From page 21	01640		
01640 SS=F	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 was revised to reflect the current services provided for three of three residents (R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01640		

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01640	Continued From page 22 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On April 20, 2026, at 10:23 a.m., clinical nurse supervisor (CNS)-B stated CNS-B developed the service plan based off each resident's assessments and any additional services requested by the resident. R5 R5's diagnoses included diabetes, hypothyroidism (underactive thyroid gland), and hyperlipidemia (high levels of fats in the blood). On April 21, 2026, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-I administered R5's scheduled topical cream to R5's legs. R5's prescriber orders dated April 13, 2026, included an order to administer Bactroban apply twice daily PRN (as needed) to any weeping leg sores. R5's Medication Sheet dated April 2026, indicated to apply Mupirocin 2% ointment apply to open areas to both lower legs twice daily PRN. Wear gloves. R5's Service Plan dated December 30, 2025, indicated R5 self-administered medications and lacked medication administration by ULPs.	01640		

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01640	Continued From page 23 On April 22, 2026, at 11:26 a.m., LALD-A and CNS-B stated R5's service plan should have been updated to include topical medication administration by ULPs. R6 R6's diagnoses included chronic kidney disease and depression. On April 21, 2026, at 7:06 a.m., the surveyor observed ULP-I administered R6's scheduled morning medication. R6's prescriber orders dated April 1, 2026, included an order for lorazepam 0.5 milligram (mg) tablet take one tablet by mouth twice daily as needed for anxiety. R6's Medication Sheet dated April 2026, indicated lorazepam 0.5 mg take one tablet by mouth twice daily as needed for anxiety. The Medication Sheet indicated R6 had received lorazepam 0.5 mg twice daily from April 1, 2026, through April 19, 2026. R6's Service Plan dated December 29, 2022, lacked medication administration by ULPs. On April 22, 2026, at 11:10 a.m., CNS-B and registered nurse (RN)-C stated ULPs administered R6's lorazepam, and R6's service plan should have been updated to reflect ULPs administering R6's medication. R7 R7's diagnoses included benign prostatic hyperplasia (BPH- noncancerous enlargement of the prostate gland) and depression. On April 21, 2026, at 8:45 a.m., the surveyor	01640		

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01640	Continued From page 24 observed ULP-I administered R7's scheduled morning medications. R7's prescriber orders dated September 19, 2025, included orders for the following medications: -Bupropion 150 mg take one tablet daily -citalopram hydrobromide 20 mg take one tablet daily -finasteride 5 mg take one tablet daily -multivitamin take one tablet daily -tamsulosin 0.4 mg take one capsule by mouth daily -Timolol solution 0.5% apply one drop into the left eye daily -vitamin D 125 micrograms (mcg) take one capsule daily -artificial tears 0.5% apply one drop into each eye twice daily R7's Medication Sheet dated April 2026, indicated R7 was administered the above noted medications as prescribed by ULPs. R7's Service Plan dated December 29, 2022, indicated R7 received medication administration by ULPs once daily. On September 18 (no year documented) indicated R7 received a medication pass twice daily with CNS-B's initials written. R7's service plan lacked authentication from R7 to change the medication pass from once daily to twice daily, including the increase in the fee. On April 22, 2026, at 11:32 a.m., LALD-A stated the licensee did not have R7 sign a new service plan to reflect the increase in fee for medication administration, and the licensee typically had new service plans signed when a change in fees for service occurred.	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 25 The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated a service plan will include a description of the services that are provided, fees for the services to be provided, the frequency of each service to be provided, and identification of staff or categories of staff who will be providing services based on the most recent assessment and resident preferences. In addition, service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 26 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of four residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01730		

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01730	Continued From page 27 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 20, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R3 R3's diagnoses included hypertension (HTN-high blood pressure) and neurocognitive disorder with Lewy bodies (a disease which affects thinking, memory, movement, and mood). R3's Service Plan dated April 12, 2023, indicated R3's services included medication assessment, set up, and administration by unlicensed personnel (ULPs). R3's prescriber orders dated February 26, 2026, included two antihypertensives, one antidepressant, one anticoagulant, four supplements, one antiparkinson, and one ophthalmic agent. On April 21, 2026, at 8:02 a.m., the surveyor observed ULP-J provide scheduled morning medication administration for R3. ULP-J opened R3's unsecured refrigerator, removed R3's Blink Tears 0.25% gel eye drops, and administered the eye drop. ULP-J stated R3 had kept the eye drops in R3's unsecured refrigerator. R3's Individualized Medication Management Plan Sample Form [sic] dated April 15, 2024, indicated medications are stored in a locked medication	01730		

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01730	Continued From page 28 cart, locked medication room, or in a locked cabinet in the resident room. R5 R5's diagnoses included diabetes, hypothyroidism (underactive thyroid gland), and hyperlipidemia (high levels of fats in the blood). R5's Service Plan dated December 30, 2025, indicated R5 self-administered medications and lacked medication administration by ULPs. R5's prescriber orders dated April 13, 2026, included one antihyperlipidemic, two antihypertensives, five supplements, one to control diabetes, and one to treat skin infections. On April 21, 2026, at 7:13 a.m., the surveyor observed ULP-I provide scheduled morning medication administration to R5. ULP-I removed R5's Mupirocin 2% ointment from R5's unsecured bathroom cabinet drawer, applied the Mupirocin 2% ointment to R5's reddened areas on R5's legs, returned the Mupirocin to R5's unsecured bathroom cabinet drawer. ULP-I stated R5 stored the Mupirocin 2% ointment in R5's bathroom cabinet. R5's Individualized Medication Management Plan Sample Form [sic] dated December 30, 2025, indicated R5 was able to safely store some medications independently (insulin, glucose tablets, Imodium) and other medications were stored in a locked medication cart. R3 and R5's individualized medication management plans did not match current medication storage for each resident. On April 22, 2026, at 11:30 a.m., CNS-B stated	01730		

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01730	Continued From page 29 R3 and R5's individualized medication management plans were not updated to reflect current medication storage, however, CNS-B stated R3 and R5 were assessed to safely store the medications noted above in their apartments. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that included a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. The medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for two of four residents (R3, R7) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 20, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R3 R3's diagnoses included hypertension (HTN-high blood pressure) and neurocognitive disorder with Lewy bodies (a disease which affects thinking, memory, movement, and mood). R3's Service Plan dated April 12, 2023, indicated R3's services included medication assessment, set up, and administration by ULPs. R3's prescriber orders dated February 26, 2026, included an order for Blink Tears 0.25 % gel instill	01750		

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01750	Continued From page 31 one to two drops into both eyes three times per day. R3's Medication Sheet dated March 2026, and April 2026, respectively, indicated R3 received Blink Tears 0.25% Gel one to two drops into both eyes three times a day. On April 21, 2026, at 8:02 a.m., the surveyor observed ULP-J provide scheduled morning medication administration for R3. ULP-J opened R3's unsecured refrigerator, removed R3's Blink Tears 0.25% gel eye drops, and administered one drop into R3's left eye. ULP-J stated the instructions indicated to give one or two drops into each eye, however, ULP-J stated R3 only wanted one drop into R3's left eye. R3's record lacked resident specific instructions on when to administer one eye drop or two eye drops of Blink Tears 0.25% Gel. R7 R7's diagnoses included benign prostatic hyperplasia (BPH- noncancerous enlargement of the prostate gland) and depression. R7's Service Plan dated December 29, 2022, indicated R7 received medication assessment, setup, and medication administration by ULPs. R7's prescriber orders dated September 19, 2025, included the following orders: -Timolol 0.5% place one drop into the left eye every morning -artificial tears 0.5% place one drop into each eye twice daily R7's Medication Sheet April 2026, indicated R7 received Timolol 0.5% one drop in the left eye	01750		

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01750	Continued From page 32 every morning, and artificial tears 0.5% one to two drops in each eye twice daily. On April 21, 2026, at 8:45 a.m., the surveyor observed ULP-I provide scheduled morning medication administration for R7. ULP-I administered one drop of Timolol 0.5 % into R7's left eye. Immediately following the administration of Timolol 0.5%, ULP-I administered one drop of artificial tears 0.5% into both of R7's eyes. R7's record lacked resident specific instructions on when to administer one eye drop or two eye drops of artificial tears 0.5%. In addition, R7's record lacked specific instructions on which eye drop to administer first and how many minutes to wait in between administering different types of eye drops. On April 22, 2026, at 10:22 a.m., ULP-I stated R7's medication administration record (MAR) did not have specific instructions on how long to wait between administering two different types of eye drops. On April 22, 2026, at 11:36 a.m., CNS-B stated ULPs were trained to wait five minutes in between administering two different types of eye drops, however, CNS-B stated the MAR lacked specific written instructions for the ULPs to follow. CNS-B further stated when an eye drop indicated one to two drops the order was directly from the pharmacy and CNS-B was unable to make edits to the eye drop orders. CNS-B stated eye drops should have written instructions on when to administer one eye drop and when to administer two eye drops. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated	01750		

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01750	Continued From page 33 August 1, 2021, indicated the RN has specified, in writing, specific instructions for each resident and document those instructions in the residents' record. The licensee's 7.34 Eye Drops and Eye Ointment policy dated January 12, 2024, indicated if more than one kind of eye drop is being used, wait at least 5 (five) minutes before using each type. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 34 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of two residents (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 20, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated February 23, 2026, indicated R1 was admitted to the facility on January 24, 2017, and discharged on February 13, 2026. R1's diagnoses included hypertension (HTN- high blood pressure) and depression. R1's Service Plan dated December 16, 2022, indicated R1's services included medication administration twice daily. R1's Medication Sheet dated January 2026, and February 2026, respectively, indicated R1	01910		

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01910	Continued From page 35 received the following medications: -acetaminophen extra strength (for pain) 500 milligrams (mg) two tablets three times per day -aspirin (for heart health) 81 mg daily -cranberry (supplement) 500 mg daily -levothyroxine (thyroid supplement) 125 micrograms (mcg) daily -metoprolol (antihypertensive) 25 mg daily -sertraline (antidepressant) 100 mg daily -vitamin B12 (supplement) 1000 mcg daily -Donepezil (for dementia) 5 mg daily -Aspercreme Lidocaine (for pain) 4% apply three times per day as needed R1's prescriber orders dated September 24, 2024, included the above noted medications. R1's Resident Discharge Summary Form dated February 13, 2026, indicated R1 moved to a different assisted living facility to be closer to a family member. R1's Medication List (medication disposition) dated February 11, 2026, included all medications noted above, however, lacked the prescription numbers for Donepezil, levothyroxine, metoprolol, and sertraline. In addition, the medication disposition documentation lacked the quantity for acetaminophen, cranberry, vitamin B12, and Aspercreme Lidocaine. On April 22, 2026, at 10:52 a.m., CNS-B stated CNS-B was not sure why some of R1's medications were not listed on R1's medication disposition record. CNS-B further stated CNS-B usually hand wrote in the medication prescription numbers on each medication disposition, however, R1's prescriptions numbers were not written in.	01910		

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01910	Continued From page 36 The licensee's 7.23 Medication Disposal policy dated April 15, 2025, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-I) observed administering medications. 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	02320		

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02320	Continued From page 37 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 20, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. ULP-I's employee record included a passed 2.29 Oral Medications Competency dated April 21, 2022. The competency included checking the medication administration record (MAR) and following the six rights of medication administration. On April 21, 2026, at 6:17 a.m., ULP-I stated ULP-I was medication trained, and competency tested upon hire with one of the licensee's registered nurses (RNs). On April 21, 2026, at 7:06 a.m., the surveyor observed ULP-I provide scheduled morning medication administration to R6. ULP-I removed one tablet of R6's lorazepam 0.5 milligram (mg) tablet from the locked narcotic medication box, placed the lorazepam tablet into the paper cup, and documented in the licensee's narcotic logbook of 33 lorazepam 0.5 mg tablets remaining. ULP-I went to R6's room and administered R6's lorazepam 0.5 mg tablet. The surveyor did not observe ULP-I compare R6's lorazepam 0.5 mg tablet to R6's electronic medication administration (EMAR) prior to the administration of R6's lorazepam 0.5 mg tablet.	02320		

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02320	Continued From page 38 On April 21, 2026, at 7:13 a.m., the surveyor observed ULP-I provide scheduled morning medication administration to R5. ULP-I removed R5's Mupirocin 2% ointment from R5's bathroom cabinet drawer, applied the Mupirocin 2% ointment to R5's reddened areas on R5's legs, returned the Mupirocin to R5's bathroom cabinet drawer, and documented Mupirocin 2% ointment was applied on R5's EMAR. The surveyor did not observe ULP-I compare R5's Mupirocin 2% ointment to R5's EMAR prior to the administration of Mupirocin 2%. On April 21, 2026, at 8:45 a.m., the surveyor observed ULP-I provide scheduled morning medication administration to R7. ULP-I opened R7's locked medication drawer, removed six pills from R7's weekly medication planner (a multi-compartment device used to store scheduled doses of medication by day and/or time) into a paper cup, administered R7's oral medications, and then proceeded to administer R7's eye drops. The surveyor did not observe ULP-I compare any of R7's medications to R7's EMAR prior to administration of the medications. On April 22, 2026, at 10:22 a.m., ULP-I stated ULP-I had known how many medications each resident received daily without reviewing the resident's EMARs and counted the pills prior to each medication administration to ensure the correct number of medications were being administered. On April 22, 2026, at 11:04 a.m., CNS-B stated ULPs were trained to review resident EMARs with each resident's medication planner to ensure the correct number of medications were in the medication planner prior to the administration of medications. CNS-B further stated all	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30294	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR MEADOWS OF MCINTOSH	325 SCOTS AVENUE SE MCINTOSH, MN 56556

(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
02320	Continued From page 39 medications were supposed to be verified with the resident's EMAR prior to the administration of any medications to complete the six rights of the medication administration process. The licensee's 2.29 Oral Medications policy dated August 1, 2021, indicated before, during, and after medication administration, check the six rights of medication administration by speaking the following out loud: Right Resident; Right Medication; Right Date; Right Time; Right Route; Right Dose [sic]. In addition, follow the facility/agency protocol for administering medication. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated an RN must instruct the ULP on the following medication administration tasks, which included the complete procedure of checking a resident's MAR, before delegating the task to them (ULPs). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Poplar Meadows Of McIntosh
325 SCOTS AVENUE SE
McIntosh, MN 56556
Polk County
Parcel:

Phone:

License Info

License: HFID 30294

Risk:
License:
Expires on:
CFPM: Rhonda Larson
CFPM #: 18510; Exp: 4/29/2029

Inspection Info

Report Number: F1049261077
Inspection Type: Full - Single
Date: 4/21/2026 Time: 11:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: THE WIPING CLOTH BUCKET TESTED AT 0 PPM QUAT. PIC REFRESHED THE WIPING CLOTH BUCKET AND THE SANITIZER RETESTED AT 200 PPM QUAT.
Comply By: Complied On Site Originally Issued On: 4/21/2026

! **New Order: 3-500A Microbial Control: cooling**
3-501.14A *Priority Level: Priority 1 CFP#: 20*
MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.
COMMENT: THE POTATO SOUP WAS COOLED THE NIGHT OF 4/20/2026. THE TEMPERATURE TESTED AT 42.6 DEGREES F, INDICATING THAT THE SOUP WAS NOT COOLED PROPERLY. PIC WAS INSTRUCTED TO DISCARD THE POTATO SOUP.
Comply By: 4/21/2026 Originally Issued On: 4/21/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.110 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.
COMMENT: THE DISH MACHINE DATA PLATE INDICATED THAT THE WASH TEMPERATURE SHOULD MAINTAIN 160 DEGREES F. THE DISH MACHINE STARTED AT 165 DEGREES F AND THEN DROPPED TO 154 DEGREES F DURING THE WASH CYCLE. PIC INSTRUCTED TO REPAIR THE DISH MACHINE SO THAT THE WASH CYCLE MAINTAINS 160 DEGREES F.
Comply By: 4/21/2026 Originally Issued On: 4/21/2026

Food & Beverage General Comment

INSPECTOR MET WITH THE ESTABLISHMENT REPRESENTATIVE AND MDH NURSE EVALUATOR.

DISCUSSED:
-VOMIT CLEAN UP PROCEDURE
-EMPLOYEE ILLNESS LOG

THE MAIN KITCHEN IS ANSI CERTIFIED WITH TILE FLOORING, FRP WALLS, AND PAINTED CEILING. THERE IS A SERVING KITCHEN ON THE SECOND FLOOR THAT HAS NON-ANSI CERTIFIED EQUIPMENT, WOOD CABINETS,

TILE FLOORING, PAINTED CEILING, AND PAINTED WALLS.

THE DISH MACHINE UTENSIL SURFACE TEMPERATURE REACHED 164.1 DEGREES F, WHICH IS COMPLIANT WITH THE FOOD CODE. HOWEVER, THE WASH CYCLE DROPPED TO 154 DEGREES F, WHICH WILL NEED TO BE REPAIRED TO MANUFACTURES SPECIFICATION (160 DEGREES F MINIMUM WASH CYCLE).

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 Fergus Falls District Office inspection report number F1049261077 from 4/21/2026

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Poplar Meadows Of McIntosh
McIntosh
County/Group: Polk County

Inspection Info

Report Number: F1049261077
Inspection Type: Full
Date: 4/21/2026
Time: 11:15 AM

Food Temperature: Product/Item/Unit: Potato Soup**; Temperature Process:** Cooling
Location: Upright Cooler at 42.6 Degrees F.
Comment: *Potato soup did not cool properly within the time/temperature parameters. PIC was instructed to discard the potato soup.
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: 2% Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Taco Meat**; Temperature Process:** Hot-Holding
Location: Steam Table at 172 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Half and Half**; Temperature Process:** Cold-Holding
Location: 2nd Floor Refrigerator at 39.1 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Poplar Meadows Of McIntosh
McIntosh
County/Group: Polk County

Inspection Info

Report Number: F1049261077
Inspection Type: Full
Date: 4/21/2026
Time: 11:15 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 0 PPM
Comment: *PIC refreshed the wiping cloth bucket and then the sanitizer retested at 200 PPM.
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 164.1 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30294016-0	**Date:** April 21, 2026
Facility Name: Poplar Meadows of McIntosh	
Facility Address: 325 Scots Ave, McIntosh, MN 56556	

☒ **TAG IDENTIFICATION: 0775**

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

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

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

   Comments: Multiple resident room doors were equipped with flip down style door stop devices. Multiple of the resident room doors were discovered to be propped open using the flip down style door stop devices. All the resident room doors had fire door labels on the frame and slab of the door, were equipped with self-closing hinges or closers, and had smoke seals around the edge of the frames.

3. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments: The second floor south stair was equipped with a deadbolt lock that was installed so that it could not be operated from the egress side without a key or a code. During the survey, director of maintenance (DM)-D removed the deadbolt lock and replaced it with a handle and latch assembly that could not be locked.

4. Where required when the building was originally constructed, materials and systems used to protect joints and voids shall be maintained. The materials and systems shall be securely attached to or bonded to the adjacent construction, without openings visible through the construction. [Minn. Stat. 144G.45 subd 2; MSFC 704.1]

   Comments: In resident room 8 there was a missing area of ceiling approximately two feet square. DM-D stated that there had been a water leak in the resident room above and they were in the process of repairing the missing ceiling.