Electronically Delivered

May 1, 2026

Licensee
Cherrywood South St Cloud
3315 Cooper Avenue South
Saint Cloud, MN 56301

RE: Project Number(s) SL32764016

Dear Licensee:

On April 28, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 19, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

Electronically Delivered

February 4, 2026

Licensee
Cherrywood South St Cloud
3315 Cooper Avenue South
Saint Cloud, MN 56301

RE: Project Number(s) SL32764016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2025, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	32764	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH 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: SL32764016-0 On December 15, 2025, through December 19, 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 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care 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		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer 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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for one of three employees (unlicensed personnel (ULP)-F) and during medication administration for two of three employees (licensed practical nurse (LPN)-D and ULP-G). In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable resident equipment for one of three employees (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 510		

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0 510	Continued From page 4 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 10:02 a.m., licensed assisted living director (LALD)-A stated the licensee provided assistance with ADLs (activities of daily living), medication management, and mechanical lift transfers to residents at the facility. HAND HYGIENE On December 15, 2025, at 11:17 a.m., the surveyor observed LPN-D enter R7's room and without performing hand hygiene, LPN-D obtained R7's blood glucose reading with R7's Dexcom (continuous glucose monitoring device). LPN-D then exited R7's room, documented the service, and went directly to R4's room. Without performing hand hygiene or applying gloves, LPN-D administered R4's scheduled inhaler. LPN-D documented the medication administration and exited the room, without performing hand hygiene. On December 15, 2025, at 11:34 a.m., LPN-D stated hand hygiene was supposed to be completed before and after all resident cares, interactions, and medications. LPN-D further stated LPN-D forgot to complete hand hygiene between R7 and R4's rooms and LPN-D was aware hand hygiene should have been completed. GLOVE USE/ SHARED REUSABLE MEDICAL EQUIPMENT ULP-F's Educare (on-line training platform)	0 510		

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0 510	Continued From page 5 Transcript indicated ULP-F completed Infection Control Techniques-BELTSS [sic] on August 17, 2025. On December 15, 2025, at 1:29 p.m., the surveyor observed ULP-F assist R2 with toileting. ULP-F put on gloves, assisted resident to standing using a mechanical lift, lowered R2's pants and removed R2's soiled brief before lowering resident with the mechanical lift to sit on the toilet. When R2 indicated R2 was done using the toilet, ULP-F assisted R2 to stand with the mechanical lift and provided peri cares. Without changing gloves, ULP-F applied barrier cream to R2's buttocks, applied a new brief, and transferred R2 to R2's recliner. ULP-F then removed ULP-F's gloves, removed and disposed of bathroom trash, and without cleaning the lift, ULP-F placed the mechanical lift and sling in the laundry room. ULP-F documented services and then completed hand hygiene. On December 15, 2025, at 1:37 p.m., ULP-F stated two residents used the mechanical lift and shared sling on the '150 side' of the building. ULP-F further stated the mechanical lift was wiped down each night with Lysol wipes and ULP-F was not aware of how often the harness was cleaned. On December 15, 2025, at 1:40 p.m., ULP-F stated ULP-F was trained by an unlicensed team leader who was no longer employed by [licensee]. ULP-F further stated ULP-F was trained to complete hand hygiene after each resident interaction and after serving meals and that gloves are worn "all the time." ULP-G's Educare Transcript indicated ULP-G completed Infection Control Techniques-BELTSS	0 510		

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0 510	Continued From page 6 [sic] on August 1, 2025. On December 15, 2025, at 4:43 p.m., the surveyor observed ULP-G administer R2's scheduled Humalog (insulin for diabetic management). ULP-F performed hand hygiene, obtained R2's blood glucose reading with use of Freestyle Libre (continuous glucose monitoring system), cleaned the hub of the insulin pen with an alcohol swab, applied safety needle, primed the needle with two units of Humalog, turned the dial to dose four units of insulin, cleaned R2's skin with an alcohol swab, and without applying gloves, ULP-G administered the insulin to R2, removed and disposed of the needle, documented the insulin administration, and performed hand hygiene. On December 15, 2025, at 4:53 p.m., ULP-G stated hand hygiene was to be completed before and after each medication administration, and resident cares. ULP-F further stated that gloves were supposed to be worn for food service and resident cares and acknowledged that ULP-F forgot to put on gloves for the insulin administration. On December 15, 2025, at 4:57 p.m., clinical nurse supervisor (CNS)-B stated all staff were trained to complete hand hygiene prior to medication administration and that gloves were to be worn for insulin administration. CNS-B further stated that when gloves are worn for resident cares, they were to be changed when going from dirty to clean tasks. On December 15, 2025, at 5:00 p.m., CNS-B stated harnesses were to be issued to each resident who utilized the mechanical lift because the harnesses were not able to be sanitized	0 510		

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0 510	Continued From page 7 between resident uses. CNS-B further stated staff were trained to clean the lift with sanitizing wipes after each use. The licensee's 8.03 Cleaning of Shared Medical Equipment policy dated August 1, 2021, indicated [licensee] implemented and maintained processes to ensure all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected before and after reuse. The policy did not specifically address the specific frequency of cleaning mechanical lifts. The licensee's 8.09 Hand washing policy dated August 1, 2021, indicated hand washing was performed by all employees between tasks and procedures to prevent cross-contaminations. The licensee's 7.36 Insulin policy dated August 1, 2021, did not address gloves being worn during insulin administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=D	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	0 775		

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0 775	Continued From page 8 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-22-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=F	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	01290		

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01290	Continued From page 9 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 background studies were affiliated with the correct health facility identification (HFID) 32764 for one of 19 employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 December 15, 2025, at 10:08 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. On December 15, 2025, at 12:18 p.m., LALD-A provided the licensee's NETStudy 2.0 (background study website) roster for HFID 32764 via email. ULP-E was hired on July 26, 2023, to provide direct care services to residents at the assisted living facility. ULP-E's employee record contained a cleared	01290		

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01290	Continued From page 10 background study for HFID 28983, dated July 11, 2023. ULP-E's record lacked a cleared background study for the licensee's HFID 32764. On December 15, 2025, at 1:22 p.m., LALD-A stated ULP-E was hired by [licensee]'s sister facility however, ULP-E transferred to [licensee] and ULP-E was not affiliated with the current location. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records will include documentation of a competed (sic) criminal background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.	01420		

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	32764	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

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01420	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks the registered nurse (RN) conducted training and competency evaluations for two of three employees (unlicensed personnel (ULP)-F 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 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: On December 15, 2025, at 10:09 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated unlicensed personnel completed training and competency testing with an RN prior to working independently. ULP-F was hired on September 1, 2023, to provide direct care services to the residents. ULP-F's employee record contained documentation to indicate ULP-F had received training and demonstrated competency for catheter care to licensed practical nurse (LPN)-C on September 12, 2023. ULP-G was hired on October 18, 2018, and on August 1, 2021, began providing assisted living	01420		

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01420	Continued From page 12 services to the residents of the facility. ULP-G's employee record contained documentation to indicate ULP-G had received training and demonstrated competency for catheter care to licensed practical nurse (LPN)-C on October 24, 2024. ULP-F and ULP-G's records lacked documentation to indicate ULP-F and ULP-G had received training and demonstrated competency for catheter care to a RN or licensed health professional (LHP). On December 18, 2025, at 3:02 p.m., LPN-C stated LPN-C stated LPN-C signed off on all competency testing at [licensee]. On December 18, 2025, at 3:44 p.m., ULP-F stated ULP-F completed competency demonstration with LPN-C. On December 19, 2025, at 7:56 a.m., clinical nurse supervisor (CNS)-B stated LPNs signed off ULP competencies. CNS-B further stated the practice of competency sign-off will need to be changed to avoid confusion. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations of ULPs were to be conducted by a RN, or another instructor may provide the training in conjunction with a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		

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01440	Continued From page 13	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of three unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01440		

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01440	Continued From page 14 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 December 15, 2025, at 10:08 a.m., licensed assisted living director (LALD)-A stated LALD-A was aware of the required contents of employee records. ULP-F was hired on September 1, 2023, to provide direct care services to residents. On December 15, 2025, from 1:29 p.m. to 1:36 p.m., the surveyor observed ULP-F assist R2 with toileting and position change. ULP-F's record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On December 16, 2025, LALD-A indicated via email "I do not have a 30 supervisory visit." The licensee's 6.17 Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff who performed delegated tasks must be provided within 30 calendar days after the date on which the individual began working for [licensee] and first performed the delegated task for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01440		

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01440	Continued From page 15 (21) days	01440		
01730 SS=F	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; (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	01730		

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01730	Continued From page 16 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 ensure the registered nurse developed individualized medication management plans for two of two residents (R2 and R3) reviewed. 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: R2 R2 was admitted to the facility on September 23, 2019, and began received assisted living services on August 1, 2021. R2's diagnoses included Alzheimer's, dementia, diabetes, hypertension (elevated blood pressure), and major depressive disorder. R2's signed Service Plan dated July 10, 2025,	01730		

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01730	Continued From page 17 indicated R2 received medication administration four times daily from a RN (registered nurse), LPN (licensed practical nurse), or TMA (trained medication aide). On December 15, 2025, at 4:43 p.m., the surveyor observed unlicensed personnel (ULP)-G administer R2's scheduled Humalog (insulin for diabetic management). R2's Individualized Medication Management Plan sample form (sic) dated July 7, 2025, indicated medication administration would be provided by facility staff and was signed by licensed practical nurse (LPN)-C. R3 R3 was admitted to the assisted living facility on April 11, 2025, and began receiving assisted living services. R3's diagnoses included diabetes, pulmonary disease (condition affecting airways or lung tissue), major depressive disorder, chronic kidney disease (kidney damage resulting in waste buildup), and retention of urine. R3's signed Service Plan dated April 11, 2025, indicated R3 received medication administration two times daily and as needed from a RN, LPN, or ULP. R3's Individualized Medication Management Plan sample form (sic) dated April 11, 2025, indicated medication administration would be provided by facility staff and was signed by LPN-C. R2 and R3's records lacked an individualized medication management plans completed by a registered nurse.	01730		

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01730	Continued From page 18 On December 17, 2025, at 11:07 a.m., LPN-C stated LPN-C completed medication management plans for the residents and that an RN reviewed them when comprehensive assessments were completed. LPN-C further stated LPN-C was not aware LPN-C could not complete the medication management plan. On December 17, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated the LPN care coordinator assisted with medication management plans. CNS-B further stated CNS-B acknowledges the medication management plan included delegation of the task to unlicensed personnel and LPNs are not able to delegate under their scope of practice. The Minnesota Board of Nursing Nurse Practice Act- Minnesota Statute Section 148.171 effective August 1, 2013, indicated on page two that delegating nursing tasks or assigning nursing activities to implement a plan of care fell under the RN scope of practice. The licensee's 7.01 Medication Management-Assessment, Monitoring, and Reassessment policy dated August 1, 2021, indicated a RN conducted a face-to-face assessment with each resident to determine which medication management services were going to be provided by the licensee. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated [licensee] developed and maintained a current individualized medication management record for each resident based on the resident's assessment and included the following required content: a statement that described the	01730		

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01730	Continued From page 19 medication management services provided, a description of the storage of medications, documentation of specific resident instructions related to the administration of medication, identified the persons who were responsible for monitoring medication supplies and ensured that medication refills were ordered on a timely basis, identified medication management tasks that were delegated to unlicensed personnel, procedures for staff to notify a RN or appropriate licensed health professional when a problem arose with medication management services, and any resident specific requirements related to documentation of medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01750		

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01750	Continued From page 20 review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the registered nurse (RN) instructed the unlicensed personnel (ULP) in proper methods to administer the medications for one of two ULPs (ULP-F) and failed to ensure the ULP demonstrated competency back to the RN for administering medications for two of two ULPs (ULP-F, ULP-G). This had the potential to affect all 15 residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on December 19, 2025. During the entrance conference on December 15, 2025, licensed assisted living director (LALD)-A stated upon hire ULPs completed online training, ULPs completed skills and medication training and competency sign-off with an RN (registered nurse), ULPs shadowed another ULP on the floor, and a 30-day supervisory was completed. ULP-F ULP-F was hired on September 1, 2023, to provide direct care services to residents. ULP-F's employee record contained Orientation Checklist- Caregiver dated September 12, 2023, which indicated ULP-F had medication	01750		

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01750	Continued From page 21 administration education at time of hire. ULP-F's employee record lacked sufficient evidence ULP-F was trained for medication administration by the RN and demonstrated medication administration competency back to the RN. On December 18, 2025, at 3:44 p.m., ULP-F stated ULP-F had been employed at the facility for a couple of years. ULP-F further stated ULP-F did not perform medication administration at time of hire and was signed off on medication administration by LPN-C. ULP-F's employee record contained a Skill Competency Medication Administration-Routes form dated September 18, 2025, which indicated ULP-F had passed medication administration. ULP-F's medication administration competency was signed by LPN-C. ULP-G ULP-G was hired on October 1, 2018, and began providing assisted living services on August 1, 2021, to residents. ULP-G's employee record lacked sufficient evidence ULP-G had demonstrated medication administration competency back to the RN. ULP-G's employee record contained documents titled Skill Competency Medication Administration-Routes and Skill Competency Medication & Treatment- Nebulizer & Inhalers, dated October 24, 2024, signed by LPN-C. ULP-G's employee file also contained a document titled Skill Competency Medication and Treatment- Insulin Administration dated November 20, 2024, signed by LPN-C.	01750		

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01750	Continued From page 22 On December 18, 2025, at 3:25 p.m., licensed assisted living director (LALD)-A stated an RN was responsible for ULP training and competency testing however an LPN assisted. On December 18, 2025, at 3:46 p.m., ULP-J stated ULP-J's medication administration training and competency testing was completed with LPN-C. ULP-J further stated an RN was not present or involved in ULP-J's medication administration competency sign-off. On December 19, 2025, at 7:56 a.m., clinical nurse supervisor (CNS)-B stated LPN's sign off on medication competencies however that practice is being discontinued due to the confusion it caused. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a RN delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client (resident) and are able to demonstrate the ability to competently follow the procedures and perform the tasks [sic]. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated ULPs must be trained and competency tested by a RN prior to insulin administration. The Minnesota Board of Nursing Nurse Practice Act- Practice of Practical and Professional Nursing dated August 1, 2013, indicated delegating nursing tasks or assigning nursing activities to implement the plan of care falls under the RN scope of practice.	01750		

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01750	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in two of three resident rooms (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on December 15, 2025, at 2:41 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	01890		

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CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH 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
01890	Continued From page 24 R2 R2 was admitted to the facility on September 23, 2019, and began receiving assisted living services on August 1, 2021. R2's Service Plan dated July 10, 2025, indicated R2 received assistance with medication administration four times daily. R2's prescriber orders dated October 6, 2025, included Aspercreme (generic- trolamine salicylate) lotion 10% (topical pain cream) apply to affected areas two times daily as needed (PRN), gabapentin (nerve pain management) 400 milligrams (mg) take one capsule two times daily, and sertraline (antidepressant) 50 mg take one time daily. On December 15, 2025, at 4:50 p.m., the surveyor observed R2's medication supply with unlicensed personnel (ULP)-G and observed the following expired medications: - Aspercreme 10%, partial tube, expired December 2024; - trolamine salicylate 10% cream, partial tube expired May 2025; - gabapentin 400 mg, quantity 10 capsules, expired October 22, 2025; - gabapentin 400 mg, quantity four capsules, expired October 22, 2025; - gabapentin 400 mg, quantity five capsules, expired October 22, 2025; - gabapentin 400 mg, quantity nine capsules, expired October 22, 2025; and - sertraline 50 mg, quantity one tablet, expired January 2025. R4 R4 was admitted to the facility on November 25, 2024, and began receiving assisted living	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32764	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH 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
01890	Continued From page 25 services. R4's Service Plan dated October 29, 2025, indicated R4 received assistance with medication administration three times daily and PRN and treatments two times daily and PRN. R4's prescriber orders dated October 6, 2025, included lisinopril (blood pressure lowering) 20 mg take one tablet one time daily and Senekot S (stool softener) 8.6-50 mg take two tablets two times daily. On December 15, 2025, at 11:24 a.m., the surveyor observed R4's medication supply with licensed practical nurse (LPN)-D and observed the following expired medications: - stimulant laxative 8.6-50 mg, partial bottle, expired on November 14, 2025; - lisinopril 10 mg, partial bottle, expired on October 24, 2025; and - lisinopril 10 mg, partial bottle, expired on July 29, 2025. On December 15, 2025, at 11:32 a.m., LPN-D stated all medication supply audits were not assigned to LPN-D however, LPN-D attempted to assist with them as time allowed. LPN-D further stated LPN-C completed medication supply audits but was unsure how often LPN-C completed audits. On December 15, 2025, at 2:57 p.m., clinical nurse supervisor (CNS)-B stated LPN-C and the facility registered nurse (RN) completed medication storage audits monthly on medication cycle fill day as well as part of any assessments. CNS-B further stated medication bottles were missed during audits.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32764	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH 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
01890	Continued From page 26 The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated expired medications managed by [licensee] were disposed of according to accepted practice of the Minnesota Board of Pharmacy and documented in the resident's medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Establishment Info

CHERRYWOOD SOUTH ST CLOUD
3315 COOPER AVENUE SOUTH
St Cloud, MN 56301
Stearns County
Parcel:

Phone:

License Info

License: HFID 32764

Risk:
License:
Expires on:
CFPM: ELIZABETH NIEHAUS
CFPM #: 125157; Exp: 9/5/2027

Inspection Info

Report Number: F1037251206
Inspection Type: Full - Single
Date: 12/15/2025 Time: 12:16:42 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! 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: CHICKEN DUMPLING SOUP IN THE UPRIGHT COOLER IN THE NORTH KITCHEN, PREPARED DURING THE NIGHT SHIFT MEASURED 45 DEG F. DISCARD SOUP. COOL HOT FOODS WITHIN 6 HOURS FROM 135 TO 41 DEG F AS OUTLINED ABOVE. COOL IN THIN SHALLOW PANS, STIR FREQUENTLY, AND LEAVE THE CONTAINER UNCOVERED UNTIL FULLY COOLED.

Comply By: 12/15/2025 Originally Issued On: 12/15/2025

Food & Beverage General Comment

DISCUSSED ORDER, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, COOLING, MENU, HIGH RISK FOODS, AND REHEATING.

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 F1037251206 from 12/15/2025

ELIZABETH NIEHAUS

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

CHERRYWOOD SOUTH ST CLOUD
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1037251206
Inspection Type: Full
Date: 12/15/2025
Time: 12:16:42 PM

Food Temperature: Product/Item/Unit: CHICKEN DUMPLING SOUP**; Temperature Process:** Cooling
Location: Upright Cooler at 45 Degrees F.
Comment: COOLING FROM OVERNIGHT SHIFT, >6 HOURS
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: HARD BOILED EGG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK JUG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MIXED VEGETABLES**; Temperature Process:** Cooking
Location: Microwave at 183 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: TUNA CASSEROLE**; Temperature Process:** Cooking
Location: Oven at 199 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PRECOOKED CHICKEN**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN DUMPLING SOUP**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MEAT SAUCE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** TUNA CASSEROLE**; Temperature Process:** Cooking
Location: Stove at 169 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MIXED VEGETABLES**; Temperature Process:** Hot-Holding
Location: Stove at 155 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

CHERRYWOOD SOUTH ST CLOUD
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1037251206
Inspection Type: Full
Date: 12/15/2025
Time: 12:16:42 PM

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

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

Minnesota (MDH) Version
EH Manager; RPT: F1037251206

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of Risk Factor/Intervention/Violations	1	Date: 12/15/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:16:42 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
CHERRYWOOD SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH	St Cloud, MN	56301	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 32764		Full		

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	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, 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	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	OUT	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

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

			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		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		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Michele L Adams

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL32764016-0	**Date:** 12/22/2025
Facility Name: CHERRYWOOD SOUTH ST CLOUD	
Facility Address: 3315 Cooper Ave S, St Cloud, Minnesota 56301	

☒ **TAG IDENTIFICATION: 0775**

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

1. Exit signs shall be illuminated at all times. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.6.3]

   Comments: The exit light at corridor of the "150" entrance did not illuminate when a test of the battery backup was initiated.