Electronically Delivered

March 27, 2026

Licensee
The Legacy of Delano
1350 St. Peter Avenue East
Delano, MN 55328

RE: Project Number(s) SL29189016

Dear Licensee:

On March 16, 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 5, 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, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

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Electronically Delivered

January 8, 2026

Licensee
The Legacy of Delano
1350 St. Peter Avenue East
Delano, MN 55328

RE: Project Number(s) SL29189016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 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 - 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
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. 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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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: SL29189016-0 On December 1, 2025, through December 5, 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 50 residents; 48 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on December 2, 2025, issued for SL29189016, tag identification 1290. An immediate correction order was identified on December 3, 2025, issued for SL29189016, tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and	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.	

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0 000	Continued From page 1 level remain unchanged.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor in	0 470		

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0 470	Continued From page 2 accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 10:17 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated, "I am the one that does the staffing plan evaluation each year, I've got it with my emergency binder and I can get it for you." On December 1, 2025, at 12:29 p.m., surveyor observed an unsigned [Licensee] Assisted Living Contingency Staffing Plan dated January 4, 2023, and marked reviewed September 2024, February 2025, and August 2025. LALD-C stated, "We don't have a spot to sign in it, but I am the one that evaluates it." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 3 (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,	0 480		

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0 480	Continued From page 4 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 1, 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 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 510		

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0 510	Continued From page 6 ULP-E began working for the licensee to providing direct cares to the residents on January 23, 2025. On December 2, 2025, from 11:55 a.m., through 12:03 p.m., during continuous observation surveyor observed ULP-E provide blood glucose monitoring and toileting to R3. ULP-E went into R3's room and without preforming hand hygiene. ULP-E obtained R3's blood glucose level via libre sensor, then pushed R3 in the wheelchair into the bathroom and removed R3's urine soiled pants and brief, and placed soiled pants on the floor, and changed R3's brief and pants, ULP-E doffed gloves and without preforming hand hygiene ULP-E donned clean gloves and picked up soiled pant and left R3s room to go to the laundry room and start the soiled pants in the wash. ULP-E then doffed gloves and without preforming hand hygiene, returned to R3s room to grab the ipad. ULP-E than left R3s room and once in the facility hallway at 12:03 p.m., ULP-E sanitized hands. On December 2, 2025, at 12:10 p.m., ULP-E stated, "We are trained that you wash your hands whenever you are starting cares, after cares, and whenever hands get dirty. I guess I didn't even realize I wasn't doing it. " On December 3, 2025, at 1:47 p.m., clinical nurse supervisor (CNS)-D stated, "They get annual training and initial training, and we do regular reminders on what times and when to wash and change gloves. After removing them and before doing anything else is when they should be washing their hands." The licensee's Infection Prevention and Control Program policy, dated January 2010, indicated,	0 510		

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0 510	Continued From page 7 the facility would implement evidence-based infection prevention and control practices including those mandated by regulatory and licensing agencies and guidelines from the Centers for Disease Control and Prevention (CDC). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=F	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	0 730		

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0 730	Continued From page 8 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for two of two discharged resident (R1 and R8). 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).	0 730		

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0 730	Continued From page 9 The findings include: R1 R1 was admitted to the licensee and began receiving services on July 5, 2023. R1 discharged on July 28, 2025. R1's records included a discharge summary dated July 29, 2025, the discharge summary lacked: - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. R8 R8 was admitted to the licensee and began receiving services on November 2, 2024. R8 discharged on January 2, 2025. R8's records included a discharge summary dated January 2, 2025, the discharge summary lacked: - a summary of the resident's stay that includes	0 730		

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0 730	Continued From page 10 diagnoses, courses of illnesses, allergies, treatments and therapies; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On December 3, 2025, at 1:47 p.m., clinical nurse supervisor (CNS)-D stated "In the discharge summary we are answering the questions like any service changes they had during the time they were here. So, I am not seeing that we have those items in our discharge assessment, we don't have it in there." The licensee's Client Record policy, dated April 2014, indicated the licensee would "Ensure medical records contain all required and pertinent information." No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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	29189	A. BUILDING: _____ B. WING _____	12/05/2025

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THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 11	0 775		
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 12-4-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 12 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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	0 810		

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0 810	Continued From page 13 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 12-4-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (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	01290		

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01290	Continued From page 14 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of twenty-six employees (unlicensed personnel (ULP)-A). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: ULP-A was hired on April 6, 2020, to perform direct care services to the licensee's residents. On December 1, 2025, during the entrance conference, surveyor requested the facility's NetStudy 2.0 (a web-based system used to submit background study requests to the Department of Human Services (DHS)) roster. The licensee's schedule dated November 30, 2025, through December 6, 2025, indicated ULP-A had worked the overnight shift from November 30, 2025 into December 1, 2025, and was scheduled to work December 2 through	01290		

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01290	Continued From page 15 December 4, 2025. ULP-A's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID 29189, effective August 1, 2021. On December 2, 2025, at 9:56 a.m., licensed assisted living director (LALD)-C stated, "I checked with HR and [ULP-A] does not have a current background study, so I have pulled him off the schedule." The licensee's Background Check Review Process policy, dated, August 1, 2025, indicated, "No one without an MNDHS (Minnesota Department of Human Services) Netstudy Clearance Letter will be allowed to begin employment." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=F	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	01440		

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01440	Continued From page 16 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 the registered nurse (RN) completed supervision of an unlicensed personnel (ULP)-B within 30 calendar days of beginning to provide delegated tasks for one of three employees. 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: ULP-B ULP-B was hired January 20, 2025, to provide direct care services to the licensee's residents. On December 3, 2025, at 8:06 a.m., surveyor observed ULP-B helped R6 with AM cares and medication administration.	01440		

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01440	Continued From page 17 ULP-B's record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On December 3, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-D acknowledge some staff were missing 30 day supervisions, and stated, "We're struggling with for some reason, the program we are using didn't trigger it to show up for us to do them, I remember I did some informal ones when I started but I didn't do paperwork for them because it was past those 30 days, but I know we are working on it." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is	01540		

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01540	Continued From page 18 complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for one of two 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective October 1, 2025, through September 30, 2026. ULP-E began working for the licensee to providing direct cares to the residents on January 23, 2025. ULP-E's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date.	01540		

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01540	Continued From page 19 ULP-E's Spark School Packet: Overview of AL Requirements, dated February 13, 2024, included "Caring for Those with Dementia" but did not specify number of hours. On December 3, 2025, at 1:47 p.m., clinical nurse supervisor (CNS)-D stated, "We are currently going through the employee training folders to see what is missing and what we are finding is that system isn't triggering it to assign that training, especially if they came from a different department, it doesn't trigger the training needed in Relias. We are maybe half way through and we are finding that some of them only have the first four hours, but the older employees, what we are finding is they had done their first four hours and then the regs changed requiring them to have eight hours, but the extra four hours never got added in for them to do, so they only have the first four hours they needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever	01610		

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01610	Continued From page 20 is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of five residents (R5) on or before the admission date. 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: R5 was admitted to the licensee and began receiving services on June 14, 2025. R5 had diagnoses to include Parkinson's disease, Alzhiemer's disease, and hypertension. R5's signed Service Agreement dated June 13, 2025, indicated R5 received assistance with ambulation, bathing, bed making, dressing, oral cares, and toileting.	01610		

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01610	Continued From page 21 R5's record included a pre-assessment opened June 4, 2025, and signed by the RN on June 20, 2025, R5's record included a Medication Sheet dated of June 1, 2025 , through June 30, 2025, that indicated R5 was receiving medication administration starting June 14, 2025, indicating 6 days had passed since admission without a completed signed assessment. On December 3, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-D stated, "Sometimes they don't come in until late, four or five in the afternoon and so they (the assessment) wont get closed until the next day. [R5] specifically I was waiting for one piece of information and then I was at a conference that whole week. The licensee's Comprehensive Assessment Schedule policy, dated July 2014, indicated, assessments would be completed according to regulation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

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01620	Continued From page 22 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for one of one resident (R5), and failed to ensure the RN completed a change of condition assessment when changes occurred for two of two resident (R3 and R6). 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). Findings include: ONGOING ASSESSMENTS R5 was admitted to the licensee and began receiving services on June 14, 2025. R5 had diagnoses to include Parkinson's disease, Alzhiemer's disease, and hypertension. R5's signed Service Agreement dated June 13, 2025, indicated R5 received assistance with ambulation, bathing, bed making, dressing, oral cares, and toileting. R5's record included an assessment opened by the RN on July 9, 2025, and signed by the RN on	01620		

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01620	Continued From page 24 July 10, 2025, and a 90 day assessment opened by the RN on October 7, 2025, and signed by the RN on October 15, 2025 indicating 97 days had passed between assessments. CHANGE OF CONDITION ASSESSMENTS R3 R3 admitted to the licensee and began receiving services on May 1, 2025. R3 had diagnoses to include type 2 diabetes, hypertension, anxiety disorder, and COPD. R3's signed Service Plan, dated July 31, 2025, indicated R3 received assistance with monthly vitals, bed making, bathing, blood glucose monitoring, dressing, laundry, medication administration, toileting, and transferring with a sit to stand. R3's change of condition assessment, dated October 21, 2025 indicated R3 used a Sara Steady (a mechanical lift used to transfer someone from a sitting to standing position). On December 2, 2025, at 11:55 a.m., surveyor observed ULP-E push R3's Sara Steady into R3's room and push R3 in a wheelchair into the bathroom and transfer R3 as a one assist with a grab bar, to the toilet. R3's record lacked a change of condition assessment to include the transfer status change. On December 3, 2025, at 6:30 a.m., ULP-G stated, "We just transfer [R3] as an assist of one with a gait belt when she lets us but she also self-transfers, we used the lifting stand when she first came back from the hospital because she	01620		

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	29189	A. BUILDING: _____ B. WING _____	12/05/2025

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01620	Continued From page 25 was weaker, but we have not used that in a while now." On December 3, 2025, at 6:44 a.m., clinical nurse supervisor (CNS)-D stated, "They told me on Friday that it was switching but I have not yet had time to switch it over, therapy basically said there was no more they could do, and she tends to self-transfer." R6 R6 admitted to the licensee and began receiving services on February 12, 2025. R6 had diagnoses to include dementia, hypertension, anxiety disorder, and COPD. R6's signed Service Plan, dated August 7, 2025, indicated R6 received assistance with monthly vitals, medication administration, laundry, and laundry. R6's Progress Notes, dated November 27, 2025, indicated R6 was admitted to the hospital. R6's Progress Notes, dated November 29, 2025, indicated R6 had returned to the licensee from the hospital. R6's record included a 90 day assessment opened by the RN on November 7, 2025, and signed and dated November 13, 2025. There were no other assessments prior to the initiation of survey. On December 1, 2025, at 10:37 a.m., clincial nurse supervisor (CNS)-D acknowledged there is no RN available to come in and do an assessment for a resident that returns from the hospital on a weekend, holiday, or after the RN's	01620		

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01620	Continued From page 26 business hours. CNS-D stated, "We do it (the assessment) on the next business day, I have one that came back on Saturday, so I am doing that today." On December 3, 2025, at 3:10 p.m., CNS-D stated, "I wasn't aware I would need to come in to do an assessment, I just thought I could do it the next working day." The licensee's Comprehensive Assessment Schedule policy, dated July 2014, indicated, assessments would be completed according to regulation requirements. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 27 (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 a written service plan was implemented no later than 14 days after the date services were first provided for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 On December 1, 2025, at 2:00 p.m., during a tour of the dementia care unit, surveyor observed R4's apartment and noted an oxygen concentrator with attached tubing located on the floor against the entry wall of the apartment. R4 was admitted to the licensee on November 28, 2023, with diagnoses that included Alzheimer's disease, essential hypertension and difficulty walking with history of falls. R4's prescriber orders signed and dated	01640		

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01640	Continued From page 28 November 16, 2025, included: - O2 to use @L via nasal cannula for O2 sats <88% and dyspnea PRN. R4's record included a Service Plan signed June 30, 2025, the service plan indicated R4 received services to include bathing, dressing, grooming, medication administration, laundry, toileting, and behavior observations. R4's record lacked a signed written service plan within 14 days of R4's start of oxygen management services. On December 3, 2025, at 3:45 p.m., clinical nurse supervisor (CNS)-D stated R4 recently went on hospice and the new orders for the oxygen were received on a weekend and she did not realize that piece of the order was not processed, this is why nothing has been updated and the treatment plan for oxygen is missing. The licensee's Service Plan policy revised September 2023 indicated All services provided to clients will be delivered after an assessment by an RN is completed, an up-to-date Service plan is signed by an RN and the client or the clients designated representative. - service addendum to the assisted living contract shall be signed on day of admission; - the home care provider shall finalize a written Service plan within 14 days after the initiation of Home Care Services to a client; - the Service plan and any revision must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided; - the Service plan must be revised, if needed, based on the results of required client monitoring	01640		

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01640	Continued From page 29 and/or reassessments; - the home care provider must implement and provide all services required by the current Service plan; - the Service plan and any revised service plans must be entered into the client's record, including notice of a change in a client's fees; and - staff providing Home Care Services must be informed of the current written Service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of one resident (R3).	01760		

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01760	Continued From page 30 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee and began receiving services on May 1, 2025. R3 had diagnoses to include type 2 diabetes, hypertension, anxiety disorder, and COPD. R3's signed Service Plan, dated July 31, 2025, indicated R3 received assistance with monthly vitals, bed making, bathing, blood glucose monitoring, dressing, laundry, medication administration, toileting, and transferring with a sit to stand. R3's Medication Sheet, dated December 1, 2025, indicated R3 received Diclofenac Gel 1 percent (%) apply 2 grams to left hand twice daily. On December 3, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare scheduled morning medications for R3. ULP-G put on gloves, and grabbed R3's Diclofenac (pain relief) gel. ULP-G looked for the measuring ruler to measure the prescribed dose, when ULP-G was unable to find the meaasuring tool, ULP-G dispensed an unknown amount of Diclofenac gel onto ULP-G's finger and verbalized two grams (gm) had been dispensed and placed it on R3's	01760		

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01760	Continued From page 31 hand. The surveyor intervened and asked ULP-G how she knew that was four grams. ULP-G stated, "I'm a stickler for using the measuring tool, but I couldn't find it and I guess I just eyeballed it since I do it all the time I kind of know roughly how much we use, but I don't have any way to know the exact amount without the tool." On December 3, 2025, at 2:15 p.m., clinical nurse supervisor (CNS)-D stated, "They (staff) are trained to wear gloves and to administer the amount that is ordered, there should be a plastic piece with measurements." The licensee's Medication & Treatments policy, dated August 2014, indicated medications would be administered following the "6 rights" which included the right dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor medication refrigerator temperatures for one of	01880		

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01880	Continued From page 32 one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 11:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated all the refrigerated medications for the facility are stored in one medication refrigerator located in the dementia care unit office. On December 1, 2025, at 2:00 p.m., during observation of the dementia care unit the surveyor observed the medication refrigerator with an unlicensed staff. The refrigerator contained several medications for the residents of the facility, a couple of the medications observed were Lantus and Ozempic injectable pens. The licensee's daily refrigerator temperature log for November 1, 2025, through December 1, 2025, indicated the temperature readings for November 2,11,15, and 16 were out of range and included readings of 70°, 73°, and 76°F to 46° Fahrenheit (F). degrees. On December 2, 2025, at 3:50 p.m., clinical nurse supervisor (CNS)-D stated the temperature should be between 35°-41° F and if it was out of range the staff should notify management, she	01880		

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01880	Continued From page 33 was not notified of any out-of-range temperatures and the out of range readings are more than likely a documentation error by the staff. CNS-D stated if she was notified of the temperature being out of range she would have the staff troubleshoot and recheck the temperature, if it was truly out of range, maintenance would be notified and the medications would be removed and relocated to another refrigerator the pharmacy would also be consulted about the incident and advise if the medications should be replaced or still able to be used, this was not completed due to she was never advised of the out of range temperatures. The manufacturer's instructions for Ozempic dated October 2025, indicated to store your new, unused pens in the refrigerator between 36°F to 46° Fahrenheit (F). The manufacturer's instructions for Lantus Solostar insulin pen dated August 2022, indicated before opening, store Lantus in the refrigerator at 36°F to 46°F. The licensee's Medications and Treatments policy, last revised March 2021, indicated medications managed by the home care provider shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910		

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01910	Continued From page 34 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1). 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	01910		

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01910	Continued From page 35 a large portion or all of the residents). The findings include: R8 was admitted to the licensee and began receiving services on November 2, 2024. R8 discharged on January 2, 2025. R8's record lacked a medication disposition to include the prescription number as applicable. On December 3, 2025, at 2:18 p.m., clinical nurse supervisor (CNS)-D stated, "I will note that we need to put the Rx numbers in when we dispose of medications going forward." The licensee's Medications & Treatments policy, dated August 2014, indicated, "Home Care staff will disposed of any medication, as needed, in a proper way including following the guidelines of the Minnesota Board of Pharmacy. An RN will be responsibe for following t he disposal procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 36 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01940		

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01940	Continued From page 37 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 1, 2025, at 2:00 p.m., the surveyor observed R4's oxygen concentrator stored against a wall in R4's apartment. R4 was admitted to the licensee on November 28, 2023, with diagnoses to include Alzheimer's disease, essential hypertension and difficulty walking with history of falls. R4's prescriber orders signed and dated November 16, 2025, included: - O2 to use 2L via nasal cannula for O2 sats <88% and dyspnea PRN. R4's Nursing Assessment dated November 19, 2025, indicated R4 received no current treatments. R4's resident record failed to include an individualized treatment plan to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of	01940		

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01940	Continued From page 38 treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On December 3, 2025, at 3:45 p.m., clinical nurse supervisor (CNS)-D stated R4 recently went on hospice and the new orders for the oxygen were received on a weekend and she did not realize that piece of the order was not processed, this is why nothing has been updated and the treatment plan for oxygen is missing. The licensee's Medication and Treatment policy revised March 2021, indicated there must be an individualized treatment plan that includes the following: - A statement of the type of services that will be provided. This is included on the service plan and is signed by the client; - Documentation of specific resident instructions relating to the treatments or therapy administration. A therapy/treatment instruction form is located in the client's apartment or in their chart; - Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. This information is identified on the service agreement; - Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - All treatment/therapy to be administered as prescribed and documented. The treatment or therapy management record must be current and updated when there are any changes or reviewed during the 90-day supervisory visits. Changes to be documented on service agreement, service	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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
01940	Continued From page 39 schedule, and a progress note is to be recorded in client chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of eleven residents (R3 and R6) with hospital-style bed rails. 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: R3 R3 admitted to the licensee and began receiving	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 40 services on May 1, 2025. R3 had diagnoses to include type 2 diabetes, hypertension, anxiety disorder, and COPD. R3's signed Service Plan, dated July 31, 2025, indicated R3 received assistance with monthly vitals, bed making, bathing, blood glucose monitoring, dressing, laundry, medication administration, toileting, and transferring with a sit to stand. On December 2, 2025, at 11:55 a.m., surveyor observed R3's bed had bilateral (two sides) half rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. On December 2, 2024, at 12:01 p.m., R3 stated, "I need them and I use them to move around in bed." R3's record included a Nursing Assessment dated October 21, 2025, which indicated R3 did not have any bedrails. R3's record lacked a Bed Safety Assessment Form to address; - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - The resident's preferences; - Installation and use according to manufacturer's guidelines; - documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation the licensee explained the risks	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 of the bed rail usage with the resident and/or the resident's representative; - evidence the licensee measured the bed rail zones of entrapment; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". On December 2, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-D stated, "It should be in her assessment, but it was marked no, I even went back to look at old assessments and it is not there." On December 2, 2025, at 1:37 p.m., CNS-D stated, "We knew about her bedrail, and I believe she even has services for it, but it got missed on the assessment for some reason." R6 R6 admitted to the licensee and began receiving services on February 12, 2024. R6 had diagnoses to include atrial fibrillation,, anxiety, and COPD. R6's signed Service Plan, dated August 7, 2025, indicated R6 received assistance with daily vitals, laundry, and medication administration. On December 3, 2025, at 8:15 a.m., surveyor observed R6's bed had one consumer style bedrail located on the right side at the head of the hospital bed. The bed rail was firmly attached to the bed. R6's record included a Nursing Assessment dated December 1, 2025, which indicated R6 did not have any bedrails.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	12/05/2025

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THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 42 R6's record lacked a Bed Safety Assessment Form to address; -The bed rail was installed, used, and maintained per manufacturer's guidelines; and -Assessment of bed rail for areas of entrapment, stability, and correct installation. On December 3, 2025, at 9:00 a.m., CNS-D acknowledged R6 had no bedrail assessment completed and stated, "[R6] got the orders for bedrails in August but had to wait forever to get them because she is elderly waiver, and we didn't get them until November. CNS-D was asked what the timeframe was for doing a bedrail assessment once a resident received bedrails, and CNS-D stated, ""I don't know, maintenance is supposed to tell us when they put them in, and family is supposed to tell us, but that doesn't always happen but we should be putting them in at least on their next quarterly assessment." The licensee's Resident Assistive Devices policy, dated August 2018, indicated, "Facility clinical staff will be responsible for completing the appropriate assessments and reviewing the risk benefits of such devices with residents and responsible parties. Any device utilized by a resident shall have a monthly Safety Check schedule to a facility nurse. Safety Checks include the following (as per Eldermark Task): -Assistive device is Secured to bed frame and device is in working order- no broken parts or patient repairs -Hospital bed rails- Zones 1, 2, 3, and 4 cannot be greater than 4.75" -Determine device still is in resident best interest- possible PT/OT eval if changes noted. All commercial assistive devices attached to a bed must be reviewed for manufacturers recall with each comprehensive assessment.Facility's	02310		

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THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

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02310	Continued From page 43 maintenance staff will be responsible for applying bed rail(s) and measurement of all areas/zones of risk to ensure the greatest safety possible with the bed rail(s). Maintenance will conduct ongoing testing of bed rail(s)/ bed frame and mattress zones. Resident is responsible for all of these costs of assessment and measurements. The facility will adhere to the following assessment and monitoring schedule: -PT/OT eval for therapeutic placement of device -Initial Assessment of the Devices- Nursing Assessment/Physical Device Tool -Quarterly Review of Device or with Change of Condition in Nursing Assessment and/or-Physical Device Assessment". The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and	02310		

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	29189	A. BUILDING: _____ B. WING _____	12/05/2025

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02310	Continued From page 44 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 45 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
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 provide care and services according to acceptable health care medical or nursing standards for resident toileting and peri care by unlicensed personnel ((ULP)-E) for one of four residents (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 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:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 46 R3 admitted to the licensee and began receiving services on May 1, 2025. R3 had diagnoses to include type 2 diabetes, hypertension, anxiety disorder, and COPD. R3's signed Service Plan, dated July 31, 2025, indicated R3 received assistance with monthly vitals, bed making, bathing, blood glucose monitoring, dressing, laundry, medication administration, toileting, and transferring with a sit to stand. On December 2, 2025, at 11:55 a.m., surveyor observed ULP-E transfer R3 from wheelchair to toilet. R3's wheelchair cushion was unine soaked, and R3's pants were visably wet all the way to the R3's knees. ULP-E removed R3's urine soiled pants and brief, placed soiled pants on the floor, without preforming peri care or washing up residents legs, ULP changed brief and pants, then laid a towel over the soiled wheelchair cushion and transferred R3 into wheelchair. On December 2, 2025, at 12:10 p.m., ULP-E stated, "I should have washed her up but she was in a hurry to get to lunch so I just did my best with the time I had." On December 3, 2025, at 2:19 p.m., clinical nurse supervisor (CNS)-D stated, 'They are trained to assist them into the bathroom and change them by putting gloves on remove the dirty stuff remove the gloves wash hands re-glove and clean them front to back." The licensee's Toileting procedure, dated February 2021, indicated, "Peri-care should be performed after each bowel movement or each	02320		

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02320	Continued From page 47 episode of incontinence. Always wipe from front to back allow, and encourage, tenant to clean him/herself if able." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Legacy of Delano
1350 St PEter Avenue East
Delano, MN 55328
Wright County
Parcel:

Phone: 7639722333

License Info

License: HFID 29189

Risk:
License:
Expires on:
CFPM: Sandra Kay Chevalier
CFPM #: 52703; Exp: 01/17/2028

Inspection Info

Report Number: F1051251180
Inspection Type: Full - Single
Date: 12/1/2025 Time: 10:50:00 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT:
AT THE TIME OF INSPECTION, THERE IS NO WATERPROOF HIGH TEMPERATURE THERMOMETER OR THERMOLABEL STICKERS USED TO MEASURE THE INTERNAL FINAL RINSE TEMPERATURE OF THE KITCHEN DISH MACHINE.
Comply By: 12/8/2025 Originally Issued On: 12/1/2025

Food & Beverage General Comment

MET WITH THE NURSE SURVEYOR, TESA BROWN.

DISCUSSED THE FOLLOWING WITH THE FOOD CULINARY DIRECTOR, SANDIE:
EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS

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 F1051251180 from 12/1/2025

Sandie Chevalier
Food Culinary Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@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

Legacy of Delano
Delano
County/Group: Wright County

Inspection Info

Report Number: F1051251180
Inspection Type: Full
Date: 12/1/2025
Time: 10:50:00 AM

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

Food Temperature: Product/Item/Unit: SLICED TOMATOES**; Temperature Process:** Cold-Holding
Location: Cold Line at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SAUSAGE LINKS**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RAW GROUND BEEF PATTY**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: DINNER SALAD CUT LETTUCE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MACARONI NOODLES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RAW GROUND BEEF**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 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

Legacy of Delano
Delano
County/Group: Wright County

Inspection Info

Report Number: F1051251180
Inspection Type: Full
Date: 12/1/2025
Time: 10:50:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 171 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1051251180

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 12/1/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:50 AM
Score (optional)		Dur: 45 min

Establishment:	Address:	City/State:	Zip:	Phone:
Legacy of Delano	1350 St PEter Avenue East	Delano, MN	55328	7639722333
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 29189		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	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	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	N/A	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	IN	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	X	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) Blai Yang

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL29189016-0	**Date:** 12/4/2025
Facility Name: THE LEGACY OF DELANO	
Facility Address: 1350 Saint Peter Ave Delano, Minnesota 55328	

☒ **TAG IDENTIFICATION: 0775**

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

1. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: During the facility tour, the surveyor observed screws in the dryer vent piping on the second level of the memory care in facility. This had the potential to collect lint and create a fire hazard for the facility.

2. 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]

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments:
   There were chairs and furniture impeding egress in the exit stairway outside of the main level dining room. The designated egress leading through the courtyard to the sidewalk was not shoveled and was blocked by snow. All exits shall be clear of all obstructions to the public way

☒ **TAG IDENTIFICATION: 0810**

DEPARTMENT OF HEALTH

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

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

   Comments: The licensee lacked documentation indicating evacuation drills were completed. Regional director of maintenance (RDM)-F stated the evacuation drills were not completed as required. No documentation was provided.