Electronically Delivered

October 16, 2025

Licensee
Claddagh Senior Living
508 Kruckow Avenue North
Caledonia, MN 55921

RE: Project Number(s) SL33458017

Dear Licensee:

On September 12, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 12, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 12, 2025, found not corrected at the time of the September 12, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on September 12, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33458	A. BUILDING: _____ B. WING _____	R 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33458017-1 On August 22, 2025, through September 12, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 12, 2025. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.	
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.	{0 485}		

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{0 485}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	

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{0 680}	Continued From page 4	{0 680}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 775} SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	{0 775}		

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{0 775}	Continued From page 5 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 29, 2025, the surveyor emailed the licensee requesting a plan of correction for the 0775 tag issued pursuant to a survey completed on June 10, 2025. On September 8, 2025, licensed assisted living director (LALD)-A responded with a correction plan and a signed agreement with an alarm company, dated August 28, 2025, to install a switch to deactivate the locks on the controlled egress exit doors in the dementia care unit. During an interview on September 12, 2025, at 2:30 p.m., LALD-A stated the alarm company was scheduled to complete installation of the switch and indicated this would be completed by October 3, 2025. Controlled egress locking systems are required to be provided with a switch or device located at the nurse station or other approved location to deactivate the locked	{0 775}		

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{0 775}	Continued From page 6 egress exit doors to allow the building occupants to evacuate in the event of an emergency. The correction plan did not include information on if the controlled egress door locks would default to the unlocked position if there was a loss of power. During an interview on September 12, 2025, at 2:30 p.m., LALD-A stated they did not know if these locks would default to the unlocked position if there was a loss of power as the facility has an emergency power generator. LALD-A stated they would contact the alarm company for more information. Controlled egress locking systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511.	{0 775}		
{0 780} SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	{0 780}		

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{0 780}	Continued From page 7 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	{0 810}		

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{0 810}	Continued From page 8 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:	{0 810}	Not reviewed during this survey.	
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	{01060}		

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{01060}	Continued From page 9 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		
{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	{01440}	Not reviewed during this survey.	

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{01440}	Continued From page 10 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey.	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}		

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{01760}	Continued From page 11 by:	{01760}	Not reviewed during this survey.	
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	{01790}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01790}	Continued From page 12 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}	Not reviewed during this survey.	
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the	{02040}		

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	33458	A. BUILDING: _____ B. WING _____	R 09/12/2025

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{02040}	Continued From page 13 assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}	Not reviewed during this survey.	

Electronically Delivered

August 12, 2025

Licensee
Claddagh Senior Living
508 Kruckow Avenue North
Caledonia, MN 55921

RE: Project Number(s) SL33458017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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.

The enclosed State Form documents no violations. MDH documents the state correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $3,000 per incident, 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
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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: SL33458017-0 On June 9, 2025, through June 12, 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 37 residents; 34 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate correction order was identified on June 10, 2025, at a level 3/Widespead (I). On June 11, 2025, the licensee took action to mitigate the risk; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 485		

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0 485	Continued From page 4 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On page four of the licensee's assisted living contract, Section 7 Services Available Through Provider; Fees included: c. Access to Food; Meal Plans. Meals are not included in the monthly rent but are available for an additional fee. Resident may elect to purchase a meal plan or may choose not to receive meals through provider. Resident must indicate resident's preference with respect to meals by completing Attachment C of this Agreement. The licensee's Attachment C: Meal Plan Addendum (part of the assisted living contract) indicated residents could choose to participate in [The Licensee's] monthly meal plan, which provides 3 (three) meals per day for $500.00 per month, or choose to opt out of the monthly meal plan. Attachment C included Meal Plan participation selection (please check one): - I would like to participate in [The Licensee's] monthly meal plan. I understand this includes 3 meals per day at the monthly rate listed above. - I do not want to participate in [The Licensee's] monthly meal plan. I understand that I will not receive any meals through provider, that a la carte meals are not available at [The Licensee] and that I will be responsible for providing all of my own meals. The Meal Plan Addendum lacked an option for residents to opt out of payment for one or two meals residents would not want. On June 11, 2025, at 1:55 p.m., licensed assisted	0 485		

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0 485	Continued From page 5 living director (LALD)-A stated the same assisted living contract was used for all residents and did not offer residents to opt out of one or two meals the resident would not want. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650		

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0 650	Continued From page 6 Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-F ULP-F was hired on July 15, 2021, to provide direct care services to residents of the facility. ULP-F's employee record lacked documented evidence of: - records of competency evaluations. On June 12, 2025, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated ULP-F was hired prior to her working there, and the above training was not documented in the employee record as required. On June 12, 2025, at 11:33 a.m., ULP-F stated she was hired and had completed a hands-on competency check-off including medication administration with a different registered nurse. ULP-F indicated she was not sure if it was documented or if papers had been filled out. The licensee's Training Records policy dated August 6, 2021, noted the licensee would	0 650		

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0 650	Continued From page 7 maintain a record of staff training and competency required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 8 Based on interview and record review, the licensee failed to practice and document testing of its emergency preparedness (EP) plan at least twice annually as required, and evaluate its missing person policy at least quarterly. In addition, the licensee failed to meet the minimum inspection and testing frequency for the emergency power generator as part of the emergency plan to ensure proper performance of the generator. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: EP PLAN TESTING The EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. MISSING RESIDENT PLAN/POLICY The licensee's 2.28 Missing Resident policy dated August 1, 2021, was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On June 12, 2025, at 12:30 p.m., licensed	0 680		

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0 680	Continued From page 9 assisted living director (LALD)-A stated she had not participated in a full-scale community-based event, conducted a tabletop exercise, or documented any emergency preparedness testing other than fire drills in the past year. LALD-A stated the missing resident plan was last reviewed on February 11, 2025, during the annual EP plan review. LALD-A stated she was not aware the missing resident plan needed to be reviewed quarterly. EMERGENCY POWER GENERATOR MAINTENANCE On June 10, 2025, at 10:15 a.m., the surveyor toured the facility with housing manager (HM)-E. During the tour, a permanently installed generator was observed on the exterior of the facility. During the facility tour interview on June 10, 2025, HM-E stated the generator was part of the emergency preparedness plan. On June 10, 2025, housing manager (HM)-E and licensed assisted living director (LALD)-A provided emergency generator documents. A review of the available documentation indicated the generator was not inspected weekly or tested monthly. During an interview on June 10, 2025, at 1:45 p.m., LALD-A and HM-E verified the power generator was part of the emergency plan and stated the generator was tested annually. Records were provided for the 2024 annual generator testing. LALD-A and HM-E stated the licensee was not aware weekly generator inspections and monthly load tests were required, and stated the frequency was not met. The minimum frequency of inspections, maintenance, and load tests are to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as	0 680		

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CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

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0 680	Continued From page 10 part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100 to ensure proper performance of the generator. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated revised July 12, 2021, identified the EP plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides (sic) and Certified Supplier Types: Interpretive Guidance." The policy included: [The Licensee] will conduct, at a minimum, two emergency preparedness drills every 12 months - these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise, or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775		

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0 775	Continued From page 11 Based on observation, record review, and interview, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. 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 June 10, 2025, HM-E and LALD-A provided building maintenance records and emergency procedures for the facility. On June 10, 2025, at 10:15 a.m., the surveyor toured the facility with housing manager (HM)-E. During the tour, the surveyor observed the following: LOCKING Controlled egress locking systems were installed on all exit doors in the dementia care unit and at the exit door leading out to the patio at the front of the building from the assisted living sitting room. During the facility tour interview on June 10, 2025, HM-E stated they did not know if these locks were tied into the building fire alarm system and would default to an unlocked (fail-safe) position if the fire sprinkler or smoke detection systems were actuated. HM-E stated they did not know if the locks would default to the unlocked position if there was a loss of power as there was an emergency power generator that provided power to maintain the locks. Additionally, the controlled egress door locking systems were not provided with a device capable of deactivating the egress door locking hardware to the unlocked position. Controlled egress	0 775		

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0 775	Continued From page 12 locking systems are required to be provided with a switch or device located at the nurse station or other approved location to deactivate the locked egress exit doors to allow the building occupants to evacuate in the event of an emergency. During the facility tour interview on June 10, 2025, HM-E stated they were not aware of a switch or button in the building that would unlock the exit doors. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress locking door system. During an interview on June 10, 2025, at 1:45 p.m., LALD-A stated they did not know if the controlled egress locking systems were tied into the building fire alarm and sprinkler systems. LALD-A stated they had already contacted a security company to evaluate the locking system for compliance with fire code rules. LALD-A stated if the locking system was found to be in compliance, information supporting the findings would be emailed to the surveyor. No further information was received as of June 23, 2025. Controlled egress locking systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. EXTERIOR EXIT GATE LOCKING In the dementia care unit, an illuminated exit sign was installed above the door leading out to a patio enclosed by a fence with a locked gate. A lock requiring a key was installed on the exit gate. This gate was part of the required marked exit path leading to the public way from the dementia care unit. During the facility tour interview on June 10, 2025, HM-E verified the above listed exit path observations. An illuminated exit sign was installed above the door leading out to the patio at the front of the building from the assisted living sitting room. A fence with a gate was installed around the patio.	0 775		

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0 775	Continued From page 13 A lock requiring a key was installed on the exit gate. This gate was part of the required marked exit path leading to the public way. The gate was not locked at the time of the tour. During the facility tour interview on June 10, 2025, HM-E verified the above listed exit path observations and stated employees would lock the gate to keep unauthorized people from entering the patio area. Egress paths leading to the public way from a marked exit door shall comply with MSFC in Minnesota Rules Chapter 7511. CARBON MONOXIDE Carbon monoxide alarms were not installed outside and within ten feet of all sleeping rooms. Fuel fired equipment was installed in the building capable of producing carbon monoxide. During the facility tour interview on June 10, 2025, HM-E verified carbon monoxide alarms were not installed. Record review of the fire alarm inspection report dated February 11, 2025, indicated carbon monoxide alarms were not installed and tied into the building fire alarm system to sound an alarm notifying building occupants of the presence of carbon monoxide. Carbon monoxide alarm and detection systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. EMERGENCY LIGHTS Emergency lights did not work when tested by HM-E in several locations throughout the building. During the facility tour interview on June 10, 2025, HM-E verified the above listed observations and stated maintenance had recently completed emergency light tests and logs would be provided after the tour. Record review of the 2025 emergency lights test log indicated tests were completed on June 1, 2025, and lights failing the	0 775		

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0 775	Continued From page 14 test had been identified. FIRE DOOR MAINTENANCE Labeled one hour fire doors were propped open with wedges on the first and second floors. Labeled 20 minute fire doors were propped open with wedges for resident rooms 102, 206, 211, and 220. During the facility tour interview on June 10, 2025, HM-E verified the above listed fire door observations. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. CEILING MAINTENANCE In the activity room closet, four ceiling tiles were missing. During the facility tour interview on June 10, 2025, HM-E verified the above listed ceiling observations. Missing ceiling tiles would allow smoke and heat to rise into the space above the ceiling and could delay fire sprinkler activation. ELECTRICAL In the public restroom on the main floor near the activity room, capped electrical wires were visable above the light fixture installed above the sink. During the facility tour interview on June 10, 2025, HM-E verified the above listed electrical observation and stated the restroom light fixture had recently been replaced. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 15 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in a resident dwelling unit that complied with fire protection requirements. 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).	0 780		

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0 780	Continued From page 16 The findings include: On June 10, 2025, at 10:15 a.m., the surveyor toured the facility with housing manager (HM)-E. During the tour of resident dwelling unit 204, the surveyor observed when the bedroom smoke alarm was tested by HM-E, the smoke alarm installed outside of this sleeping unit was not actuated. During the facility tour interview on June 10, 2025, HM-E verified the above listed smoke alarm observations. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 17 (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 record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, make all parts of the plan readily available, and provide required training. 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 potential to affect a large portion or all of the residents). The findings include: On June 10, 2025, housing manager (HM)-E and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 18 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review indicated the FSEP did not include evacuation procedures for the individualized unique needs of residents. During an interview on June 10, 2025, at 1:45 p.m., LALD-A stated residents requiring staff assistance in an emergency had been identified and these procedures were maintained electronically as part of the care plans. These individualized evacuation procedures were not included with the printed copy of the FSEP in the red emergency policies and procedures binder stored at the front desk. All parts of the FSEP must be maintained as readily available for accessibility. The licensee FSEP dated January 1, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Employees were directed to evacuate residents to a safe assembly point outside of the smoke compartment, but smoke compartments were not identified in the plan. Doors on magnetic holders were inaccurately referenced. The pages were blank where the FSEP indicated a facility floor plan and site map were to be inserted. The FSEP failed to include fire safety and evacuation instructions for residents evident by no written procedures in the plan. The FSEP included standard resident evacuation procedures but failed to provide site specific	0 810		

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0 810	Continued From page 19 procedures for resident movement and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan. During an interview on June 10, 2025, at 1:45 p.m., LALD-A and HM-E verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a review of training records lacking the required frequency and documentation. The surveyor requested records for resident fire safety and evacuation training completed between June 2024 and June 2025 from LALD-A and HM-E. One 2025 training record with eight resident names listed was provided. The date of this training was not recorded. The current census for the facility indicated there were 37 residents. No additional training records were provided. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by a review of training records lacking the required frequency and documentation. A new hire training record dated May 28, 2025, from a third party online training company was provided. This new hire training did not include the site specific FSEP. FSEP training records for February and March 2025 were provided. The names of the employees who had participated in these trainings were not recorded. During an interview on June 10, 2025, at 1:45 p.m., LALD-A and HM-E verified the training frequencies and documentation were lacking. LALD-A stated eight residents were capable of	0 810		

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0 810	Continued From page 20 self evacuation and that was why only eight residents had participated in the 2025 fire safety and evacuation training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 21 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 began receiving assisted living services on August 12, 2021, with diagnoses of bilateral hearing loss, dry eyes, and hypertension (high blood pressure).	01060		

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01060	Continued From page 22 R3's Service Plan Addendum dated February 5, 2025, indicated R3 received assistance with bathing, compression stockings, and medication administration. R3's observations (identified as progress notes) dated March 28, 2025, at 11:57 a.m., indicated R3 had been transferred to the hospital. R3's progress notes dated April 2, 2025, at 1:51 p.m. identified R3 had discharged from hospital and returned to the facility (five days later). R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On June 11, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated no written notice was provided to R3 or any resident that had been emergently relocated	01060		

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01060	Continued From page 23 unless they were gone more than four days. Though the licensee had an emergent relocation form with the required components, CNS-B and RN-C stated they had misunderstood the regulation and thought the notice only needed to be given out if the resident was relocated greater than four days. In addition, CNS-B and RN-C stated they had not notified the Ombudsman for Long-Term Care since the resident was returning. The licensee's 1.23 Emergency Relocation policy dated July 27, 2022, noted in the event of an emergency relocation, the licensee will provide a written notice that would be delivered as soon as practicable to: a. The resident, legal representative, and designated representative; b. For residents who receive home and community-based waiver services, the resident's case manager; and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01440		

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01440	Continued From page 24 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 June 10, 2025, at 8:19 a.m., the surveyor	01440		

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01440	Continued From page 25 observed ULP-D administer medications to R2. ULP-D was hired on December 24, 2024, to provide direct care services to residents at the assisted living. ULP-D's employee record lacked evidence of a RN supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. On June 12, 2025, at 10:12 a.m., clinical nurse supervisor (CNS)-B stated ULP-D lacked the required 30-day supervision of delegated tasks. CNS-B further stated she was unaware of the supervision requirement. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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	01760		

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01760	Continued From page 26 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed by one of two employees (unlicensed personnel (ULP)-D) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses included Alzheimer's dementia. R6's Service Plan Addendum to Contract dated February 17, 2025, included medication administration. R6's prescriber orders dated March 28, 2025, included an order for diclofenac sodium external gel 1%. Apply 4 grams (measured using dosing card) to affected area four times a day. R6's medication administration record (MAR)	01760		

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01760	Continued From page 27 dated June 1, 2025, through June 10, 2025, included diclofenac sodium 1% gel apply 4 grams to affected area four times a day. On June 10, 2025, at 10:23 a.m., the surveyor observed ULP-D prepare and administer medications to R6. ULP-D reviewed R6's MAR and obtained R6's diclofenac sodium 1% gel from the medication cart. ULP-D took a disposable plastic medication cup and squeezed the diclofenac sodium 1% gel into the cup to the line labeled 4 drams. Wearing gloves, ULP-D then applied the medication to R6's hands. ULP-D then returned to the medication cart and documented the medication administration. When interviewed at this time, ULP-D stated she thought the medication cup was labeled grams not drams. ULP-D stated she was not aware how to measure 4 grams utilizing the plastic dosing card that comes with the medication. On June 10, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated staff were taught and instructed to use the plastic dosing card that comes with the medication for an accurate measurement of the medication. According to a dram (dr) to gram (g) Conversion calculator dated 2025, 4 drams is equivalent to 7.08738078125 grams. The licensee's 7.42 Topical Application of Ointment & Cream policy dated August 1, 2021, noted medications must be applied according to the prescriber orders. The policy further included medications always need to be administered according the "6 Rights" - Right person - Right medication	01760		

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01760	Continued From page 28 - Right time - Right route (by mouth, eye drop, to the skin) - Right dose (how many milligrams, drops) - Right chart/record to document that the medication was taken. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures	01790		

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01790	Continued From page 29 regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for two of two employees (unlicensed personnel (ULP)-D, ULP-F) providing medications for residents with	01790		

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01790	Continued From page 30 unplanned time away from home when the licensed nurse was not available. 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 included: ULP-D was hired on December 24, 2024. ULP-F was hired on July 15, 2021. ULP-D and ULP-F's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On June 12, 2025, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated both ULP-D and ULP-F administered medications and would encounter times when they would need to get medications ready for a resident to take with them for unplanned time away. CNS-B stated she verbally instructs staff on the process but does not document this. CNS-B stated ULP-D and ULP-F's employee record lacked the above required competency. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, noted when a pharmacist or licensed nurse is not available, the registered	01790		

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01790	Continued From page 31 nurse may delegate this task to unlicensed personnel if: - the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02040		

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02040	Continued From page 32 safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 10, 2025, housing manager (HM)-E and licensed assisted living director (LALD)-A provided physical environment documents. An undated hazard vulnerability analysis was provided. This assessment identified human, technology, and natural hazards. The analysis did not identify safety risks on and around the property with mitigation factors to protect dementia care residents from harm. During an interview on June 10, 2025, at 1:45 p.m., HM-E and LALD-A verified the hazard vulnerability analysis that had been completed did not include physical environment hazards with mitigation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
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 ensure care and services were provided according to acceptable	02310		

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02310	Continued From page 33 health care and medical or nursing standards for one of one resident (R5) with a consumer bed rail and one of one resident (R2) with a hospital bed rail. This resulted in an immediate correction order issued on June 10, 2025. 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: On June 10, 2025, at 8:45 a.m., the surveyor observed R5's queen sized bed to have a rectangle shaped consumer purchased bed rail, which was secured on the upper right side of the bed to a board that slid under the mattress. R5 stated she used the bed rail to assist with getting in and out of bed and repositioning. R5's diagnoses included dementia. R5's Service Plan Addendum dated January 6, 2025, indicated R5 received services including bathing and medication administration. R5's record lacked: - an assessment for the current bed rail use; - evidence of risk vs. benefits education on bed rail use with R5 or R5's responsible party; - evidence R5's bed rail was used, installed, and maintained per manufacturer's instructions; and - evidence R5's bed rail was checked for recalls with the Consumer Product Safety Commission	02310		

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02310	Continued From page 34 (CPSC). R2 On June 10, 2025, at 8:19 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2 in his room. The surveyor observed a hospital bed with raised bilateral upper bed rails in R2's room. R2 diagnoses included Alzheimer's dementia. R2's Service Plan Addendum dated June 3, 2025, indicated R2 received services including dressing, grooming, bathing, positioning, transfers, toileting, hospice, behavior intervention, catheter care, and medication administration. R2's record included a Risk Agreement- Bed Positioning Device form signed by R2's representative on March 24, 2025. R2's record lacked: - an assessment for the current bed rail use; - measurements for the current bed rail; and - evidence the bed rails were Food and Drug Administration (FDA) compliant; On June 10, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated R5 and R2's records lacked the information as noted above. CNS-B and RN-C indicated they were not aware of the documentation requirements for bed rails and the information would be lacking for all residents that had a bed rail in the facility. The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated the following: When [licensee name] is aware a home care resident is utilizing side rails (a medical device)	02310		

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02310	Continued From page 35 on a bed, [licensee name] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. The FDA, "A Guide to Bed Safety" revised April 2010, included the 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 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:	02310		

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02310	Continued From page 36 - 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". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated for portable consumer bed rails, the licensee should ensure: - an assessment was completed; - the bed rails were determined to not act as a restraint; - the portable bed rails were installed and maintained according to the manufacture's guidelines; - the manufacturer's guidelines are accessible upon request; and - the risk vs benefits were discussed and documented with the resident/responsible party. The MDH website also indicated for hospital-style bed rails, the licensee should ensure: - an assessment was completed; - measurements were completed and documented; - the rails are FDA compliant; and - the risk vs benefits was discussed and	02310		

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CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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 37 documented with the resident/responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On June11, 2025, the licensee implemented actions to mitigate the risk to R5 and R2. Scope and severity remain at I.	02310		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Claddagh Senior Living
508 Kruckow Ave N
Caledonia, MN 55921
Houston County
Parcel:

Phone: 507-725-5200
office@claddaghseniorliving.com

License Info

License: HFID 33458
Melissa Nickerson
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1045251018
Inspection Type: Full - Single
Date: 6/10/2025 Time: 11:39:15 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-500A Microbial Control: cooling
3-501.14A *Priority Level: Priority 1 CFP#: 20*
MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.
COMMENT: LEFTOVER FRATTATAS FROM THE MORNING MEAL WERE OBSERVED WITH AN INTERNAL PRODUCT TEMPERATURE OF 80F APPROXIMATELY 3 HRS AFTER THEY WERE PLACED IN THE COOLER. PRODUCT WAS STORED APPROXIMATELY 4-5" DEEP IN A TIGHTLY SEALED CONTAINER. DISCUSSED PROPER COOLING PRACTICES. FIRM DISPOSED OF THE PRODUCT
Comply By: Complied On Site Originally Issued On: 6/10/2025

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: TIGHTLY COVERED PRODUCT (CALZONES AND FRATTATAS) WERE OBSERVED DEEPLY PACKED AND SNUGGLY COVERED DURING CRITICAL COOLING TIMES. DISCUSSED SPREADING THE PRODUCT OUT AND KEEPING THE PRODUCT UNCOVERED WHILE IN THE PROCESS OF COOLING. *FIRM DISCARDED AFFECTED PRODUCT AND WILL ADJUST PRACTICES
Comply By: Complied On Site Originally Issued On: 6/10/2025

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: HANDWASHING SINK LOCATED IN THE SERVING AREA WAS BLOCKED BY A LARGE BOX AND NOT ACCESSIBLE DURING THE SERVING TIME. FIRM REORGANIZED SPACE
Comply By: Complied On Site Originally Issued On: 6/10/2025

Food & Beverage General Comment

Facility is a Senior Living Establishment with a complete kitchen supplying morning/afternoon/evening meals to residents.

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 Rochester District Office inspection report number F1045251018 from 6/10/2025

Melissa Nickerson
Manager

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us