Electronically Delivered

October 21, 2025

Licensee
Cherrywood St Cloud
1030 Voyageur Street
Saint Cloud, MN 56303

RE: Project Number(s) SL28983016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD ST CLOUD	1030 VOYAGEUR STREET SAINT CLOUD, MN 56303

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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 SL28983016-0 On September 15, 2025, through September 17, 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 17 residents; all 17 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	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: 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 September 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make menus available to residents at least one week in advance. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	0 485		

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0 485	Continued From page 4 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour with licensed assisted living director (LALD)-B on September 15, 2025, at 10:10 a.m., the surveyor observed a menu in the two dining rooms titled Summer Week 2 Menu 2025, for a one week period. On September 17, 2025, at 9:30 a.m., housing manager (HM)-H stated he only posted the current week's menu. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 510		

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0 510	Continued From page 5 Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of one employee (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 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 September 16, 2025, at 8:51 a.m., the surveyor observed ULP-F assist R1 with medication administration and incontinence cares. After administration of oral medications, ULP-F donned (put on) gloves, checked R1's incontinent brief, which was wet through to the sheets, unfastened the wet brief, provide perineal cares in the front, tuck the sheets under R1's right side, assisted R1 to roll to the left, provided perineal cares to the back, remove the wet sheet and brief, placed a clean brief under R1's right side, administered Preparation H Cream (hemorrhoid cream) to R1's rectum, wiped the tip of the applicator with a wipe, removed the glove from her right hand, placed the new sheet and soaker pad with, adjusted R1's pillow, and assisted R1 to turn to the right. ULP-F then removed her left glove, and rolled R1 to her back after pulling the sheet and soaker pad out on the right side, fastened the brief in front, fixed the	0 510		

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0 510	Continued From page 6 sheets on the left side, adjusted the pillow, moved the oxygen tubing over R1's knees, rolled R1 to the right and placed a pillow behind her back and between her knees and lower legs. At this time, ULP-F covered R1 with a sheet, touched the remote to raise the head of the bed, placed a glove on her right hand and returned the Preparation H to the medication cupboard in R1's room, locked the cupboard and removed the keys, and went to the bathroom to wash her hands. On September 16, 2025, at 9:20 a.m., ULP-F stated she had removed the glove from her right hand after performing perineal cares, but had not performed hand hygiene, and said this was how she was trained to do it. On September 16, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated staff are expected to perform hand hygiene after removing gloves and between dirty and clean tasks. The licensee's Hand Washing policy dated August 1, 2021, noted hand washing should be completed after changing incontinence briefs. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.1 indicated: 1). Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient;	0 510		

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0 510	Continued From page 7 b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code (MSFC) in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 775		

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0 775	Continued From page 8 affect a large portion or all of the residents). The findings include: On September 17, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with housing manager (HM)-H, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: EXIT DOOR LOCKING and PATH OF EGRESS: The marked exit door from the resident hallway into the Great Room, adjacent to the Riser Room, was equipped with an electromagnetic lock. The marked exit door from the Great Room to the outside was equipped with an electromagnetic lock. The path of egress to exit the resident hallway through the Great Room requires the building occupant to pass through more than one door equipped with a controlled egress lock. A building occupant shall not be required to pass through more than one door equipped with a controlled egress lock before entering an exit. FIRE RESISTANT RATED DOORS The fire-resistant rated doors from the resident hallway on each side of the Great Room did not close and latch. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency. These deficient conditions were visually verified at the time of discovery by HM-H accompanying on the tour.	0 775		

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0 775	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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 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.	0 810		

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0 810	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 17, 2025, licensed assisted living director (LALD)-B and housing manager (HM)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 9.06 Fire Policy, dated August 1, 2021, failed to include the following: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to	0 810		

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0 810	Continued From page 11 evacuate residents but did not include any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. All residents were identified as need assistance to evacuate in a fire or similar emergency. On September 17, 2025, at 1:30 p.m., LALD-B stated they would develop procedures for each resident's specific evacuation assistance needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies	01290		

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01290	Continued From page 12 were affiliated with their health facility identification (HFID) for one of four employees (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 15, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required contents of an employee record. ULP-D was hired on April 19, 2024, to provide direct care services to residents of the facility. ULP-D's employee record included a background study clearance letter dated October 11, 2024, submitted through a separate license of an affiliated company. On September 15, 2025, at 11:10 a.m., LALD-B stated the licensee was affiliated with the attached health system, and the background study clearance letter for ULP-D had not been affiliated with the license's HFID. In addition, LALD-B stated ULP-D worked at both locations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01290		

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01290	Continued From page 13 days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	01500		

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01500	Continued From page 14 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (clinical nurse supervisor/CNS-A). 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).	01500		

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01500	Continued From page 15 The findings include: CNS-A was hired on March 27, 2017, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record lacked documented evidence of the required annual training to include: - reporting maltreatment of vulnerable adults or minors; - infection control techniques; and - principles of person-centered planning/service delivery. On September 17, 2025, at 10:26 a.m., CNS-A and licensed assisted living director (LALD)-B stated the training had been assigned but not completed by CNS-A. The licensee's Annual Required Staff Training policy dated August 1, 2025, noted the training must be completed every twelve months including: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-F, ULP-G) received	01540		

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01540	Continued From page 17 the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility held an assisted living with dementia care license effective January 1, 2025, with a current census of 17 residents. During the entrance conference on September 15, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they were aware of the contents of the employee record. CNS-A CNS-A was hired on March 27, 2017, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. ULP-F ULP-F was hired on May 30, 2014, to provide direct care services to the facility's residents.	01540		

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01540	Continued From page 18 ULP-F's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. ULP-G ULP-G was hired on December 16, 2024, to provide direct care services to the facility's residents. ULP-G's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. On September 17, 2025, at 10:26 a.m., CNS-A and licensed assisted living director (LALD)-B stated the required training had been assigned to all staff but not completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01790 SS=F	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	01790		

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01790	Continued From page 19 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 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	01790		

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01790	Continued From page 20 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) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 15, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, lacked written procedures to include: - the type of container or containers to be used	01790		

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01790	Continued From page 21 for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - 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; - 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; - 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 - 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. On September 17, 2025, at 10:21 a.m., CNS-A stated the procedures had been typed up by a former employee, but she was unable to locate them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01910	Continued From page 22	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01910		

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01910	Continued From page 23 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 discharged to an assisted living facility on September 15, 2025. R3's diagnoses included mild neurocognitive disorder and malignant neoplasm of bladder and prostate. R3's Service Plan, signed by R3's representative on March 20, 2025, indicated R3 received services including assistance with dressing, grooming, toileting, and medication administration. R3's discharge summary note dated September 15, 2025, noted R3 discharged to another assisted living facility. R3's Discharge Medication List dated September 15, 2025, noted the medication names, indications, doses, administration schedule and quantity. However, it lacked the prescription numbers. On September 17, 2025, at 10:22 a.m., clinical nurse supervisor (CNS)-A stated they typically include the prescription number under the medication name, but it had not been included for R3's medication disposition. The licensee's Medication Disposal policy dated August 1, 2021, noted documentation must include the prescription numbers. No further information was provided.	01910		

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01910	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=F	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 the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R4, R1) with an assistive device, and for two of two residents (R1, R2) with hospital-style bed rails. In addition, the licensee failed develop and implement new interventions related to the root cause of falls for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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). This practice resulted in an immediate order for correction on September 16, 2025.	02310		

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02310	Continued From page 25 The findings include: ASSISTIVE DEVICE R4 During the facility tour on September 15, 2025, at 10:10 a.m., with licensed assisted living director (LALD)-B, the surveyor observed R4 in his room on his bed with an assistive devices underneath the left side of the couch. The device appeared to be a fixed cane. LALD-B stated she was not aware what this was for. On September 16, 2025, at 8:35 a.m., the surveyor observed R4's device with clinical nurse supervisor (CNS)-A. The device was a Stander brand Couchcane black pole type device with a handle on the top with an opening for the hand, and was attached to a long piece on the floor with two parallel attached non-slip base pieces on the floor going beneath each end of the long piece. The non-slip ends were below the feet on the left side of the couch. R4 stated he did not use the device. R4's diagnoses included dementia, diabetes mellitus type II, pain, and gout. R4's Service Plan dated June 20, 2025, indicated R4 received services including assistance with dressing, grooming, toileting, medication administration, and assistance with transfers and mobility. R4's Senior Living Assessment dated July 11, 2025, noted R4 demonstrated inappropriate judgment related to safety, has mild/moderate/severe memory loss, has moderate disorientation or difficulty recalling/retaining information, and has moderate	02310		

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02310	Continued From page 26 dementia with significant short-term memory and possibly long-term memory loss. It noted R4 had pain related to arthritis, and has bladder and bowel incontinence. It noted R4 is able to get in and out of bed and chair without assistance, and has a history of falls, and has had cognitive decline. On September 16, 2025, at 8:30 a.m., CNS-A stated R4's device had not been assessed, she was not aware when it was brought in by family, and added R4's family brought things in without notifying staff. In addition, she said staff had not notified nursing of the device. CNS-A stated it would be removed, and there was no need to assess R4 since he had recently been assessed. On September 16, 2025, at 10:25 a.m., CNS-A stated per staff, the device was there since Friday, September 12, 2025, staff were trained to notify nursing of a new device, but had not notified nursing. She was also waiting for a call back from family related to the device. On September 16, 2025, at 10:40 a.m., unlicensed personnel (ULP)-F stated Friday, September 12, 2025, R4's family had asked her why the device had been removed from near the couch and had placed it back there. ULP-F stated this device came in with R4 when he admitted to the facility. In addition, ULP-F stated R4 does sit on his couch when he has company, but mainly sits in his recliner or bed. On September 16, 2025, at 10:59 a.m., CNS-A noted in an email message the device had no current recall. R4's Progress Note dated September 17, 2025,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD ST CLOUD	1030 VOYAGEUR STREET SAINT CLOUD, MN 56303

(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 27 effective September 16, 2025, at 11:13 a.m., noted "Resident (sic) niece installed a couch cane on resident's couch without prior approval or assessment from RN [registered nurse] for need. Resident's current capabilities are able to stand without assistance by pushing up from bed/couch/recliner/chair without any difficulty. Through staff interview and resident interview, resident does not sit on his couch. Resident prefers to sit on his bed or in his recliner. POA [power of attorney] was called and she is in agreement that it is not needed. Niece will be in to pick up couch cane and remove from building (sic)." On September 17, 2025, at 9:23 a.m., the surveyor observed R4 asleep in his bed, and the Couchcane device had been removed from underneath the left side of the couch. On September 17, 2025, at 10:15 a.m., CNS-A stated she had done a note in R4's record and removed the Couchcane. The Stander Produce and Contact Information dated October 23, 2024, noted under Warnings "This product is for adult use only. It is not intended to be used by individuals who have paralysis, symptoms of dementia, sleeping disorders, incontinence, pain, uncontrolled body movement, or are unable to walk safely without assistance. It should not be used by individuals who suffer from confusion, restlessness, terminal restlessness, or are under the influence of medications, drugs or any substance that could impair their balance or judgment, or any other unforeseeable reasons that could affect the users physical and mental ability to safely use this product. If you have questions, please consult a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 28 physician before using this product. This product is not intended to carry the full weight of an individual. This product is only intended to provide balance and support while sitting and standing." R4's record lacked a comprehensive assessment of the use of an assistive device, including the intended purpose of the device, whether the device had the effect of being an improper restraint, the condition and description of the device, a need assessment, discussion of the risk versus benefits, the resident's preferences, a physical inspection for areas of entrapment, stability, and correct installation per the manufacturer's guidelines. It lacked indication the device had been checked for a recall with the Consumer Product Safety Commission (CPSC). R1 During the facility tour on September 15, 2025, at 10:10 a.m., with LALD-B, the surveyor observed R1 in her bed with a white pole that went from floor to ceiling near the right side of a recliner. R1's diagnoses included anxiety, major depressive disorder, obstructive sleep apnea, and muscle weakness. R1's Service Plan dated February 5, 2025, indicated R1 received services including assistance with dressing, grooming, toileting, bathing, transfers, and medication administration. R1's Senior Living Assessment dated June 12, 2025, noted R1 was not always oriented, demonstrated anxious/paranoid behaviors, transferred with an EZ stand (mechanical standing device) and one staff, required	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD ST CLOUD	1030 VOYAGEUR STREET SAINT CLOUD, MN 56303

(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 29 assistance getting in and out of the chair, had bilateral vision loss and did not wear glasses, was at risk for falls due to poor vision, poor cognition and weakness, and had slightly limited sensory perception. On September 16, 2025, at 10:05 a.m., CNS-A stated she did not have any documentation on the pole and had reached out to therapy to see if they could provide the information. On September 16, 2025, at 10:15 a.m., CNS-A stated R1 had not been assessed for the use of the pole because she thought it was considered a medical device like a bar in the bathroom, it was brought in years ago by therapy, R1 has not used it in some time, and she thought it had been removed. The Healthcraft Products Inc. SuperPole undated manufacturer guidelines noted "People with Alzheimer's disease, dementia or other neurological conditions, or those who are sedated, confused, or frail, are at increased risk of entrapment, suffocation and strangulation." R1's record lacked a comprehensive assessment of the use of an assistive device, including the intended purpose, whether the device had the effect of being an improper restraint, the condition and description of the device, a need assessment, discussion of the risk versus benefits, the resident's preferences, a physical inspection for areas of entrapment, stability, and correct installation per the manufacturer's guidelines. It also lacked indication the device had been checked for a recall with the CPSC. HOSPITAL BED RAIL	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 30 R1 During the facility tour on September 15, 2025, at 10:10 a.m., with LALD-B, the surveyor observed R1 in her bed with bilateral hospital-style bed rails in the raised position. R1's Side Rail (bed rail) Assessment dated September 8, 2025, noted R1 utilized the bed rail for assistance with mobility and repositioning, the device was not a restraint, and met the Food and Drug Administration (FDA) recommendations. On September 17, 2025, at 9:48 a.m., the surveyor observed CNS-A measure R1's bilateral hospital-style bed rails affixed to the hospital bed. Both rails were in the raised position. The nine openings between the bars for zone 1 varied in size from 2 1/4 inches to 3 3/4 inches. Zone 2 measurements, under the rail, between the rail supports, measured 0 inches. The measurements between the mattress and bed rail for zone 3 measured one inch. R1's record lacked a comprehensive assessment of the hospital-style rails to include indicate whether they were securely attached per manufacturer guidelines. R2 During the facility tour on September 15, 2025, at 10:10 a.m., with LALD-B, the surveyor observed R2's bed with bilateral hospital-style bed rails in the raised position. R2's diagnoses included Alzheimer's disease and hypertension. R2's Service Plan dated June 20, 2025, indicated R2 received services including assistance with	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 31 dressing, grooming, toileting, and medication administration. R2's Senior Living Assessment dated June 23, 2025, noted R2 had impaired cognition related to Alzheimer's disease, had pain related to arthritis, required physical assistance with transferring including use of an EZ stand, and was resistive to cares. R2's Side Rail Assessment dated July 8, 2025, noted R2 utilized the bed rail for bed mobility, repositioning, and sitting on the edge of the bed. On September 17, 2025, at 9:40 a.m., the surveyor observed CNS-A measure R2's bilateral hospital-style bed rails affixed to the hospital bed. Both rails were in the raised position. The nine openings between the bars for zone 1 varied in size from 2 1/4 inches to 3 3/4 inches. Zone 2 measurements, under the rail, between the rail supports, measured 0 inches. The measurements between the mattress and bed rail for zone 3 measured one inch. R2's record lacked a comprehensive assessment of the hospital-style rails to include indicate whether they were securely attached per manufacturer guidelines. On September 17, 2025, at 10:00 a.m., CNS-A stated R1 and R2's assessment lacked the above required content. 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	02310		

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	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 32 the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. 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	02310		

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02310	Continued From page 33 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." FALLS R2's diagnoses included Alzheimer's disease and hypertension. R2's Service Plan dated June 20, 2025, indicated R2 received services including assistance with dressing, grooming, toileting, and medication administration. R2's Senior Living Assessment dated June 23, 2025, noted R2 had impaired cognition related to Alzheimer's disease, had pain related to arthritis, required physical assistance with transferring including use of an EZ stand, and was resistive to cares. R2's record included the following: - Incident Report (IR) dated March 3, 2025, at 3:20 a.m., noted R2 fell with no injury. Interventions included checking vital signs each shift. Progress Note (PN) dated April 16, 2025, at 11:53 a.m., titled "RN FOLLOW UP FROM, INCIDENT REPORT ON 3/3/25" noted "Resident has a history of falls and has no regard for own safety. Resident has all proper all interventions in place at this time." A second PN dated April 16, 2025, at 12:58 p.m., noted "Resident has all proper fall interventions in place at this time."; - PN dated March 21, 2025,at 9:47 p.m., noted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 34 R2 was found on her bottom on the floor by her bed. No new interventions were noted; - PN dated March 29, 2025, at 7:45 p.m., noted staff was found self-transferring into bed, partially off the bed. No new interventions were noted; - PN dated April 6, 2025, at 4:00 a.m., noted R2 was found on the floor by staff. Interventions included checking vital signs; - PN dated May 9, 2025, at 10:30 a.m., noted R2 was observed from the hallway to slide out of bed onto the floor. R2 was helped off the floor and complained of pain in the buttocks. Interventions included monitor and update; - PN dated May 23, 2025, at 1:40 p.m., noted "Resident needed the EZ stand x3. Resident very weak with transfers." No new interventions were noted; - PN dated May 24, 2025, at 1:56 p.m., noted "Resident needed the EZ stand x3. Only transferred with walker and transfer belt x1. Resident having hard time standing." No new interventions were noted; - PN dated May 26, 2025 at 8:11 p.m., noted an attempt to pivot transfer with difficulty, and EZ stand was used for the rest of the shift. No new interventions were noted; - IR dated June 1, 2025, at 7:30 a.m., noted R2 fell in their room. Instructions included checking vital signs every shift for 24 hours; - PN dated June 1, 2025, at 8:30 a.m., noted staff were transferring resident using a pivot transfer and R2's legs gave out. No new interventions were noted; - PN dated June 2, 2025, at 10:59 p.m., noted as a fall follow up lacked any new interventions; - PN dated June 3, 2025, at 10:30 a.m., noted as a follow up from the incident on June 1, 2025, noted "Resident has a history of falls and has no regard for own safety. All proper fall interventions	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 35 are in place at this time."; - PN dated June 3, 2025, at 1:11 p.m., noted resident was weak with transfers that morning. No new interventions were noted; - IR dated June 18, 2025, at 7:00 a.m., noted R2 had a fall in her room. Instructions included checking vital signs every shift for 24 hours; - PN dated June 18, 2025, at 12:10 p.m., noted R2 was being hooked to the EZ stand and slid off the bed. Instructions included checking vital sings for 24 hours each shift; - PN dated June 23, 2025, at 3:40 p.m., noted R2 was in the bathroom after being transferred by staff with the EZ stand, and reported she fell backwards onto the toilet. No new interventions were noted; - PN dated July 8, 2025, at 12:53 p.m., noted as a follow up from incident on June 18, noted resident had a witnessed fall when getting up out of bed using the EZ stand. R2 pushed the EZ lift away and slid to the ground. All proper fall interventions in place at this time; and - PN dated September 10, 2025, at 11:45 a.m., noted R2 was assisted with a pivot transfer from her chair to the wheelchair and her knees bent and slowly went to the floor. No new interventions. On September 16, 2025, at 2:15 p.m., CNS-A stated no new interventions other than checking vital signs had been initiated for any of R2's falls. The licensee's Fall policy dated August 1, 2021, noted the licensed practical nurse (LPN) and registered nurse (RN) would identify potential causes and possible interventions to help prevent further falls or injury from falls. No further information was provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	09/17/2025

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02310	Continued From page 36 TIME PERIOD FOR CORRECTION: Seven (2) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Cherrywood of St Cloud
1030 Voyageur Street
St Cloud, MN 56301
Stearns County
Parcel:

Phone:

License Info

License: HFID 28983

Risk:
License:
Expires on:
CFPM: Robin M. Bauck
CFPM #: 125139; Exp: 8/8/2027

Inspection Info

Report Number: F1046251108
Inspection Type: Full - Single
Date: 9/15/2025 Time: 11:30:18 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 4-200 Equipment Design and Construction

4-201.11AMN *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: 1) THE "GE" COOLERS ARE NOT ANSI APPROVED, ARE MARKED WITH "HOUSEHOLD REFRIGERATOR". REPLACE "GE" COOLERS WITH ANSI APPROVED COOLERS. FACT SHEET WILL BE SENT WITH REPORT.

2) REMOVE ALL CROCK POTS FROM ESTABLISHMENT, THEY ARE NOT ANSI APPROVED. REPLACE WITH AN ANSI APPROVED WARMER.

Comply By: 3/15/2026 Originally Issued On: 9/15/2025

New Order: 5-500 Refuse and Recyclables

5-501.114 *Priority Level: Priority 3 CFP#: 54*

MN Rule 4626.1295 Maintain drain plugs in place in receptacles and waste handling units for refuse, recyclables, and returnables that are designed with drains.

COMMENT: REFUSE RECEPTACLES WERE MISSING DRAIN PLUGS. PROVIDE DRAIN PLUGS.

Comply By: 9/29/2025 Originally Issued On: 9/15/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1046251108 from 9/15/2025

Establishment Representative

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

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

Temperature Observations/Recordings

Establishment Info

Cherrywood of St Cloud
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046251108
Inspection Type: Full
Date: 9/15/2025
Time: 11:30:18 AM

Food Temperature: Product/Item/Unit: PULLED CHICKEN**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: 150 SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: BERRY FLUFF**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: 150 SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: 140 SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: 140 SIDE
Violation Issued?: No

Food Temperature: Product/Item/Unit: RIBS**; Temperature Process:** Hot-Holding
Location: Oven at 195 Degrees F.
Comment: 140 SIDE
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Cherrywood of St Cloud
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046251108
Inspection Type: Full
Date: 9/15/2025
Time: 11:30:18 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment: 150 SIDE
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment: 140 SIDE
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment: 150 SIDE
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment: 140 SIDE
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1046251108

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 9/15/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:30:18 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Cherrywood of St Cloud	1030 Voyageur Street	St Cloud, MN	56301	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 28983		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: