Electronically Delivered

January 15, 2026

Licensee
Oak Park Place of Albert Lea
1615 Bridge Avenue
Albert Lea, MN 56007

RE: Project Number(s) SL30707016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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 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
	30707	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF ALBERT LEA	1615 BRIDGE AVENUE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30707016-0 On December 16, 2025, through December 19, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 49 residents; 49 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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. 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: The licensee had an Assisted Living with Dementia Care license effective May 1, 2025. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five and six of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420		

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on February 26, 2025. As a result of this survey, the following orders were issued under 0470, 0480, 0485, 0580, 0660, 0730, 0775, 0800, 0810, 1460, 1620, 1640, 1790, 1820, 1890, 1910, 1940, 2040, 2110, 2140, and 2170, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

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0 470	Continued From page 3 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was reviewed twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 470		

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0 470	Continued From page 4 a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a bed capacity of 62 residents. At the time of the survey, there were 49 residents; 49 receiving services under the Assisted Living Facility with Dementia Care license. On December 19, 2025, at 12:27 p.m., assisted living director in residence (ALDIR)-A provided the licensee's staffing plan and metrics. ALDIR-A stated she was newly employed and unable to locate evidence the staffing plan had been reviewed twice yearly as required. The licensee's undated, Direct Care Staffing Plan, noted the staffing plan would be reviewed, at a minimum, two times each year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480		

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0 480	Continued From page 5 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 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	0 480		

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0 480	Continued From page 6 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 17, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious	0 485		

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0 485	Continued From page 7 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's Meal/Food Plan Addendum (part of the assisted living contract) indicated residents could choose one of the following Meal/Food plan	0 485		

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0 485	Continued From page 8 options: - Three meals each day for $400 per month - Two meals each day for $350 per month The Meal Plan Addendum lacked an option for residents to opt out of payment for one or no meals residents would not want. On December 18, 2025, at 10:38 a.m., assisted living director in residence (ALDIR)-A stated the same assisted living contract was used for all residents and did not offer residents to opt out of meals the resident would not want. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 580		

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0 580	Continued From page 9 licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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) 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: On December 18, 2025, at 2:08 p.m., registered nurse (RN)-C indicated the licensee had held meetings but there had been a change in management and was not sure where the previous manager had kept the notes. RN-C was unable to provide documentation of any quality management activity. The licensee's 2.31 Quality Management Project policy dated April 13, 2023, indicated the licensee would have at least one documented quality management project in place at all times and retain records of such projects for at least two years. The quality management documentation should be made available, upon request, to Minnesota Department of Health surveyors and investigators. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 660	Continued From page 10	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of two employees (unlicensed personnel (ULP)-F, ULP-H). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 660		

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0 660	Continued From page 11 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's TB risk assessment was completed July 22, 2025, and was determined to be a low risk level. ULP-F began providing direct care services for the licensee on April 28, 2025. ULP-H began providing direct care services for the licensee on October 31, 2023. ULP-F and ULP-H's record lacked evidence of a TB history and symptom screen or TB testing completed upon hire. On December 19, 2025, at 10:42 a.m., registered nurse (RN)-C stated there were no symptom screen or TST results in ULP-F or ULP-H's employee file. RN-C did not know why this was lacking from the employee files. The licensee's TB Prevention and Control policy dated July 22, 2025, noted upon hire all staff would be screened for TB symptoms and tested for TB with either a two-step Mantoux (skin test) or an IGRA laboratory blood test. The results of the TB test will be recorded and kept in the employee's medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July	0 660		

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	30707	A. BUILDING: _____ B. WING _____	12/19/2025

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0 660	Continued From page 12 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 13 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the client record included a discharge summary for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 730		

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0 730	Continued From page 14 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5's diagnoses included dementia, history of falling, and osteoarthritis (form of arthritis with pain, stiffness, and decreased mobility). R5 discharged from the licensee on October 31, 2025. R5's record included a Progress Note dated November 4, 2025, indicating R5 had discharged to another facility and medications were sent with. R5's record lacked a discharge summary. On December 17, 2025, at 9:44 a.m., registered nurse (RN)-C stated she had only completed a progress note identifying R5 had been discharged to another facility and that the medications were sent with. RN-C stated she was not aware of the discharge summary required components and further indicated this had not been completed for R5. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 17, 2025 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 17, 2025 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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:	0 810		

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0 810	Continued From page 17 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 17, 2025 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of	01460		

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01460	Continued From page 19 the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. 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:	01460		

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01460	Continued From page 20 ULP-F was hired on April 28, 2025, to provide direct care and services to the facility's residents. On December 18, 2025, at 9:21 a.m., the surveyor observed ULP-F administer medications to R3. ULP-F's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On December 19, 2025, at 10:40 a.m., registered nurse (RN)-C stated ULP-F's employee record lacked the above orientation training topics. RN-C indicated ULP-F had come from another assisted living employer with transcripts of completed trainings. RN-C was not aware orientation wasn't portable between separate employers. The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated April 17, 2023, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01460		

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01460	Continued From page 21 person -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	01620		

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

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01620	Continued From page 23 residents (R2, R3, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R2 R2 began receiving assisted living services on March 18, 2025. R2's Service Plan Report revised last April 20, 2025, indicated R2 received services including bathing, dressing, grooming, behavior interventions, safety checks, housekeeping, laundry, and medication administration. R2's record included a Comprehensive Assessment dated March 31, 2025, and a Comprehensive Assessment dated July 31, 2025. The July 31, 2025, assessment was 122 days from the date of the previous assessment, thus exceeding 90 calendar days. R3 R3 began receiving assisted living services on February 19, 2025. R3's Service Plan Report dated December 17, 2025, indicated R3 received assistance with bathing, housekeeping, laundry, blood sugar checks, and medication administration.	01620		

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01620	Continued From page 24 R3's last three assessments were requested. Comprehensive Assessments dated February 21, 2025, June 10, 2025, and September 9, 2025, were provided. The June 10, 2025, assessment was 109 days from the last date of the assessment, thus exceeding 90 calendar days. In addition, the September 9, 2025, assessment was 91 days from the last date of the assessment, thus exceeding 90 calendar days. R1 R1 began receiving assisted living services on January 28, 2025. R1's Service Plan Report dated August 7, 2025, indicated R1 received assistance with bathing, dressing, dressing, grooming, toileting, transferring, housekeeping, laundry, and medication administration. R1's record included a Comprehensive Assessment dated August 5, 2025, and a Comprehensive Assessment dated November 4, 2025. The November 4, 2025, assessment was 91 days from the date of the previous assessment, thus exceeding 90 calendar days. On December 19, 2025, at 8:16 a.m., registered nurse (RN)-C stated the above-named assessments were late. RN-C further stated the licensee had been between nurses during that time and was aware there were some late assessments. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated April 13, 2023, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed	01620		

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01620	Continued From page 25 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF ALBERT LEA	1615 BRIDGE AVENUE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 26 services provided for one of three residents (R1). In addition, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for two of three residents (R2, 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 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: R1 R1's diagnoses included diabetes. On December 17, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's blood sugar. R1's Service Plan Report dated August 7, 2025, indicated R1 received assistance with bathing, dressing, dressing, grooming, toileting, transferring, housekeeping, laundry, and medication administration. The service plan did not include blood sugar checks. R1's prescriber orders dated November 26, 2025, included an order for blood sugar checks twice daily. R1's medication administration record (MAR)	01640		

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01640	Continued From page 27 dated December 1, 2025, through December 16, 2025, indicated R1 received blood sugar checks twice daily. On December 19, 2025, at 10:13 a.m., registered nurse (RN)-C stated R1's service plan lacked the treatment of blood sugar checks, and it should have been included. R2 R2's diagnoses included depression, suicidal ideations, and dementia. R2's Service Plan Report revised last April 20, 2025, indicated R2 received services including bathing, dressing, grooming, behavior interventions, safety checks, housekeeping, laundry, and medication administration. The service agreement lacked a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. R3 R3's diagnoses included diabetes, anxiety, and osteoarthritis (form of arthritis leading to pain, stiffness, and decreased mobility). R3's Service Plan Report revised last December 16, 2025, indicated R3 received services including bathing, toileting, hygiene, housekeeping, laundry, blood sugar checks, and medication administration. The service agreement lacked a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On December 18, 2025, at 11:07 a.m., registered nurse (RN)-C stated both R2 and R3's service	01640		

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01640	Continued From page 28 plans were lacking signatures and indicated they should be signed by both the resident/resident's responsible party and the licensee. The licensee's 6.08 Service Plan policy dated revised April 13, 2023, noted a service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences. The service plan and any revisions shall include a signature or other authentication by the assisted living and by the resident or the resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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	01790		

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01790	Continued From page 29 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 personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility,	01790		

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01790	Continued From page 30 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)-F, ULP-H) providing medications for residents with 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-F was hired on April 28, 2025. ULP-H was hired on October 31, 2023. ULP-F and ULP-H's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On December 19, 2025, at 10:15 a.m., registered nurse (RN)-C stated ULP-F and ULP-H were both trained to administer medications and would encounter times when they would need to get medications ready for a resident to take with them	01790		

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01790	Continued From page 31 for unplanned time away. RN-C stated both employee records lacked the above required competency. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy revised April 13, 2023, noted competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescriber orders for one of seven residents (R4) was complete. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number	01820		

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01820	Continued From page 32 of staff are involved, or the situation has occurred only occasionally). The findings include: R4's unsigned, Service Plan Report dated December 16, 2025, included medication administration. On December 17, 2025, at 8:01 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R4's medications, including diclofenac sodium (topical pain gel) 1% to R4's lower back. ULP-E stated the MAR did not include a dosage to apply, but she would apply 2 grams using the dosing card since she was applying the gel to R4's lower back. ULP-E further explained the dosing card instructed to apply 2 grams to upper body and 4 grams to the lower body. R4's prescriber orders dated November 10, 2025, included: - diclofenac sodium 1% gel to low back twice daily. R4's medication administration record (MAR) dated December 1, 2025, through December 18, 2025, included: - diclofenac sodium 1% gel; apply to low back topically two times a day for back pain. R4's record lacked the following: -complete prescriber orders to include the medication dose for the diclofenac sodium 1% gel as noted above. On December 18, 2025, at 1:18 p.m., registered nurse (RN)-C stated R4's diclofenac sodium 1% gel as listed above did not include the dose. RN-C further stated she would need to clarify the	01820		

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01820	Continued From page 33 order with the prescriber for the dosage. The licensee's 7.17 Medication & Treatment Orders - Receiving policy dated April 13, 2023, noted content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for one of seven residents (R6) 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	01890		

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01890	Continued From page 34 situation has occurred only occasionally). The findings include: R6's diagnoses included dementia, anxiety, and diabetes. R6's Service Plan Report dated December 2, 2025, included medication administration. R6's prescriber orders dated December 15, 2025, included: - hydroxyzine (antihistamine) 25 milligrams (mg) take 2 tablets by mouth twice a day as needed for itchiness. R6's medication administration record (MAR) dated December 1, 2025, through December 19, 2025, included the medication as ordered above. On December 17, 2025, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-G administer medications to R6. The hydroxyzine had a label that directed to administer one 25 mg tablet twice daily as needed for itchiness. When interviewed at this time, ULP-G stated the label for R6's hydroxyzine did not match the MAR but said she would follow the MAR instead of the label. On December 18, 2025, at 1:14 p.m., registered nurse (RN)-C stated there should have been a direction change sticker on the medication label. RN-C further stated the prescription label should match the current prescriber orders and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. 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 for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01910		

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01910	Continued From page 36 The findings include: R5 was admitted to the licensee on January 14, 2022, and discharged on October 31, 2025, to another facility. R5's service plan dated July 2, 2025, indicated R5 received services including medication administration. R5's prescriber orders dated October 30, 2025, indicated R5 received the following medications: - memantine (for dementia) 5 milligrams (mg) daily - fluoxetine (antidepressant) 10 mg daily - amlodipine (for blood pressure) 5 mg daily - metoprolol tartrate (for blood pressure) 50 mg twice daily - lansoprazole (for stomach acid) 30 mg daily R5's record lacked a disposition of medications to include the medication 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. On December 17, 2025, at 9:44 a.m., registered nurse (RN)-C stated R5's record lacked a disposition of medication form for all the medications the licensee managed. RN-C stated she had sent all the medications with the resident when he discharged to another facility. The licensee's 7.23 Medication Disposal policy dated April 13, 2023, noted: Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

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01910	Continued From page 37 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

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01940	Continued From page 38 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R6, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 16, 2025, at 1:31 p.m., assisted living director in residence (ALDIR)-A and registered nurse (RN)-C stated the licensee provided treatment management services to residents, including blood sugar checks. R6 On December 17, 2025, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-G check R6's blood sugar. R6's diagnoses included diabetes. R6's Service Plan Report dated December 2,	01940		

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01940	Continued From page 39 2025, included blood sugar checks as ordered. R6's prescriber orders dated December 15, 2025, included: blood sugar check daily. R6's medication administration record (MAR) dated December 1, 2025, through December 19, 2025, indicated R6 had received blood sugar checks daily. R1 On December 17, 2025, at 10:58 a.m., the surveyor observed ULP-F check R1's blood sugar. R1's diagnoses included diabetes. R1's Service Plan Report dated August 7, 2025, failed to include blood sugar checks. R1's prescriber orders dated November 26, 2025, included: blood sugar check twice daily. R1's MAR dated December 1, 2025, through December 19, 2025, indicated R1 had received blood sugar checks twice daily. R6 and R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On December 18, 2025, at 11:33 a.m., registered nurse (RN)-C stated R6 and R1's record lacked a treatment management plan to include all the required content as noted above. RN-C stated there should be blood sugar parameters, so staff know when to notify the nurse.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF ALBERT LEA	1615 BRIDGE AVENUE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 The licensee's 7.15 Treatment - Administration & Delegation policy dated April 13, 2023, indicated the RN would specify, in writing, specific instructions for each resident and document those instructions in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=D	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 observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	12/19/2025

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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
02040	Continued From page 41 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 17, 2025 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 42 (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in for three of three residents (R1, R2, R3) who resided in an assisted living with dementia care 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	02110		

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	30707	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 43 The findings include: The licensee held an assisted living with dementia care license effective through April 30, 2026, and was licensed for a bed capacity of 62 residents. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limited the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of resident's possessions. On December 18, 2025, at 1:11 p.m., registered nurse (RN)-C stated the dementia care policies	02110		

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	30707	A. BUILDING: _____ B. WING _____	12/19/2025

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02110	Continued From page 44 had been developed but not provided to the residents. RN-C stated there had been changes to the licensee's management team and this had been overlooked. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated April 10, 2023, identified the required policies and procedures would be provided to residents and the residents' legal and designated representatives at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors.	02140		

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02140	Continued From page 45 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: The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license effective May 1, 2025. During the entrance conference on December 16, 2025, at 1:31 p.m., assisted living director in residence (ALDIR)-A stated clinical nurse supervisor (CNS)-B and registered nurse (RN)-C oversaw the staff training in the care of individuals with dementia. On December 18, 2025, at 1:11 p.m., RN-C stated a previous employee held the certificate and was no longer employed with the licensee. RN-C stated there was not a current designated staff member who had completed the supervisory dementia training as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities	02170		

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	30707	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 46 according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all	02170		

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02170	Continued From page 47 provisions and failed to develop an individualized activity plan based on the evaluation for one of two residents (R1) who resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a client'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: The facility held an assisted living with dementia care license effective May 1, 2025, with a current census of 49 residents. R1 was admitted on January 28, 2025, with diagnoses that included diabetes and altered mental status. On December 17, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's blood sugar. R1's Service Plan Report dated August 7, 2025, indicated R1 received assistance with bathing, dressing, dressing, grooming, toileting, transferring, housekeeping, laundry, and medication administration. R1's record lacked an individualized written activity evaluation that addressed: -past and current interests; -current abilities and skills; -emotional and social needs and patterns;	02170		

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02170	Continued From page 48 -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan based on the activity evaluation. On December 19, 2025, at 12:41 p.m., assisted living director in residence (ALDIR)-A stated they were unable to locate an activity assessment or plan for R1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Food & Beverage Inspection Report

Establishment Info

Oak Park Place of Albert Lea
1615 Bridge Ave
Albert Lea, MN 56007
Freeborn County
Parcel:

Phone: 507-373-5600

License Info

License: HFID 30707

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044251299
Inspection Type: Full - Single
Date: 12/17/2025 Time: 8:33:56 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Results not submitted to MDH.
Comply By: 06/17/2027 Originally Issued On: 12/17/2025

! **New Order: 3-500A Microbial Control: cooling**
3-501.14A *Priority Level: Priority 1 CFP#: 20*
MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.
COMMENT: Chicken in upright cooler cooled on 12/16 measured at 45 degrees F. Chicken was cooled in an ice bath initially, but did not reach the required 41 degrees F within 6 hours.

Chicken moved to shallow pan to rapidly cool while on site.
Comply By: 12/17/2025 Originally Issued On: 12/17/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Upright cooler in memory care holding TCS foods above 41 degrees F.

Scalloped potatoes discarded while on site.
Comply By: 12/17/2025 Originally Issued On: 12/17/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Susan Kalis. Inspection report reviewed on site with Sherri Johannsen.

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 F8044251299 from 12/17/2025

Sherri Johannsen
Foodservice Director

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30707016-0	**Date:** December 17, 2025
Facility Name: OAK PARK PLACE OF ALBERT LEA	
Facility Address: 1615 BRIDGE AVE, ALBERT LEA, MN, 56007	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: The controlled egress system was not equipped with a separate de-activate signal or switch to unlock the system.

3. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.8.1]

   Comments: The facility had 3 controlled exit doors in the memory care area that open to a patio with one gate, that was secured shut with a chain and padlock.

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

   Comments: The memory care area egress exit doors leading to the patio where obstructed by snow and ice. There was not a clear path from the exit door to the patio gate.

5. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hard-wired smoke alarms in multiple resident rooms, were over 10 years past the manufacturer date. All smoke alarms shall be replaced with smoke alarms having the same type of power supply.

6. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Facility didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances.

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

   Comments: Several resident room fire doors equipped with self-closing hinges no longer worked, preventing the door from closing and latching.

☒ **TAG IDENTIFICATION: 0800**

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

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: On the second floor, in a storage room that was once a "tub room", there was a large section of drywall missing.

☒ **TAG IDENTIFICATION: 0810**

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

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP doesn't included standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: ALDIR-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

☒ **TAG IDENTIFICATION: 2040**

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

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: Facility did have a hazard vulnerability assessment (HVA) completed with percentages assigned to each vulnerability, the assessment was missing mitigations to take when and if those hazards happened.