Electronically Delivered

March 26, 2026

Licensee
Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN 55711

RE: Project Number(s) SL33366016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 23, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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,



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
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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: SL33366016-0 On February 17, 2026, through February 23, 2026, 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 21 residents; 21 receiving services under the Assisted Living Facility 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 420	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: During the entrance conference on July 17, 2026, at 10:16 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and director (D)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee had an assisted living license, effective November 1, 2025, with an expiration date of October 31, 2026.	0 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 420	Continued From page 2 The licensee's renewal "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 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 owner/authorized agent on August 19, 2025. As a result of this survey, the following orders were issued under 0480, 0510, 0650, 0730, 0775, 0800, 0810, 1290, 1370, 1380, 1440, 1470, 1530, 1550,1620, 1640, 1690, 1750, 1880, 1890, 1910, 1940, 1950, 3090, 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 480 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 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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 480	Continued From page 4 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 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 February 17, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 480	Continued From page 5 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control for five of five residents (R2, R4, R5, R6, R7) who received blood glucose monitoring. 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 510	Continued From page 6 portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided blood glucose monitoring for the residents of the facility. CNS-B stated most of the residents checked their own blood glucose and reported the results to staff. CNS-B stated residents' blood glucose supplies were kept in a basket and each blood glucose meter was labeled with the resident's initials. Director (D)-O stated staff were to prompt the residents to check their blood glucose and encourage them to check in a private area but ultimately it was the resident's choice. Licensed assisted living director (LALD)-A stated the licensee practiced person centered care and allowed residents to be as independent as possible. The licensee's Current Resident Roster dated February 17, 2026, identified five residents (R2, R4, R5, R6, R7) who received blood glucose monitoring. On February 19, 2026, at 9:48 a.m., the surveyor observed a basket on top of the microwave in the dining room that contained five individual blood glucose meters with resident initials on the covers and a sharps container was located near the basket. On February 20, 2026, at 1:29 p.m., CNS-B stated CNS-B never considered storing all the residents' blood glucose meters together in a basket in the dining room would be a breach of infection control. The surveyor and CNS-B observed the residents individual blood glucose	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 510	Continued From page 7 meters all stored together in a basket on top of the microwave in the dining room. In the basket contained resident blood glucose meters, a few alcohol prep pads, food crumbs, coins, and other items they did not belong in the basket. There were no disinfecting supplies available for residents to use to disinfect the area before or after residents checked own blood glucose. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated April 30, 2025, reusable equipment and environmental surfaces would be properly disinfected after use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 650	Continued From page 8 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required annual training content for each 12 months of employment for one of one employee (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 February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents for an employee record. ULP-D was hired on June 14, 2018, under the previous comprehensive home care license and began providing direct care services for the residents at the assisted living facility August 1, 2021. On February 17, 2025, at 10:10 a.m., the surveyor observed ULP-D in the kitchen	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 650	Continued From page 9 preparing meals for the residents. At 2:58 p.m., ULP-D stated ULP-D prepared meals and provided direct care for the residents at the facility. The licensee's Revised Policies and Procedures 2025 signature sheet directed to signed when reviewed. The signature sheet lacked ULP-D's signature indicating ULP-D had not reviewed the policies and procedures in 2025 as required. ULP-D's employee record lacked annual review of the facility's policies and procedures relating to the provision of assisted living services, and how to implement those policies and procedures for annual training for the years of 2024 and 2025. On February 18, 2026, at 11:26 a.m., CNS-B stated staff were to sign off on a signature sheet when staff reviewed of the licensee's 2025 policies and procedures. CNS-B confirmed with ULP-D, ULP-D's signature was not on the sign off sheet. ULP-D stated ULP-D recalled reviewing the licensee's policies and procedures; however, could not recall the date. The licensee's Assisted Living Annual Trainings policy dated April 30, 2026, indicated all assisted living employees would complete annual education on the following topics:-review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 730	Continued From page 10	0 730		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the 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	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 730	Continued From page 11 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with all required content for one of one resident (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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R1's diagnoses included schizophrenia, anxiety, bi-polar, paranoid delusions, visual hallucination, and suicidal thoughts. R1's undated Discharge/Transfer Summary	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 730	Continued From page 12 indicated R1 services began August 2, 2022, and was discharged on December 23, 2025. R1's discharge summary lacked a complete summary of R1's care and services provided by the licensee, R1's baseline status at the time of discharge, and post discharge plan. On February 19, 2026, at 12:44 p.m., CNS-B stated CNS-B printed R1's discharge summary from Residex (electronic health care record software program) and confirmed the R1's summary did not include a recap of R1's services, discharge location or discharge plan. CNS-B stated she was unaware of the required content in a discharge summary and would have to contact Residex to expand the discharge summary template. The licensee's Discharge Summary policy dated April 30, 2025, indicated the licensee would write a summary of the resident's assisted living stay. A discharge summary would be written by the time of discharge and would include: -diagnoses; -course of illness; -allergies; -treatments; -therapies; -pertinent lab results; -pertinent radiology results; -pertinent consultation results; -final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral and functional status. -reconciliation of all pre-discharge medications with post discharge prescribed and over the counter medications; -post discharge plan developed with the resident,	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 730	Continued From page 13 and if the resident consents, resident's representative. The post discharge plan would include: -resident's planned residence; -arrangement made with follow up care; and -needed post discharge medical and non-medical services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. 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: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 14 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Physical Environment Inspection Report (PEIR) dated February 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 780	Continued From page 15 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 780	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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:	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 800	Continued From page 17 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
0 810	Continued From page 18 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, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 19	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction 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 observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for four of ten employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F, ULP-G). In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for three of ten employees ULP-H, ULP-I, ULP-J. This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 20 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on February 18, 2026. During the entrance conference on February 17, 2026, at 10:16 a.m., through 11:22 a.m., director (D)-C stated the licensee was aware of the required content of an employee record and D-C was identified as responsible for employee background studies. COVID-19 EXPIRED BACKGROUND STUDIES ULP-D ULP-D was hired on June 14, 2018, under the previous comprehensive home care license and began providing direct care services for the residents at the assisted living facility August 1, 2021. On February 17, 2025, at 10:10 a.m., the surveyor observed ULP-D in the kitchen preparing meals for the residents. At 2:58 p.m., ULP-D stated ULP-D prepared meals and provided direct care for the residents at the facility. ULP-D's employee record lacked a Department of Human Services (DHS) Background Study Clearance Letter. The licensee's February 2026 staff schedule indicated ULP-D was scheduled to work 19 out of 28 days, from 6:30 a.m., to 2:30 p.m. and from 7:00 a.m., to 7:30 a.m., ULP-D worked alone.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 21 ULP-E ULP-E was hired July 17, 1997, under the previous comprehensive home care license and began providing direct care services for the residents at the assisted living facility August 1, 2021. ULP-E's employee record contained a cleared background study notice issued by DHS dated June 17, 2020. The licensee's February 2026 staff schedule indicated ULP-E was scheduled to work 16 out of 28 days,11:00 p.m., to 7:00 a.m., and one person worked the shift alone. ULP-F ULP-F was hired June 14, 2018, under the previous comprehensive home care license and began providing direct care services for the residents at the assisted living facility August 1, 2021. ULP-F's employee record contained a cleared background study notice issued by DHS dated March 9, 2020. The licensee's February 2026 staff schedule indicated ULP-F was scheduled to work 19 out of 28 days either 6:30 a.m., to 2:30 p.m., or 7:30 a.m., to 3:30 p.m. ULP-G ULP-G was hired September 30, 1998, under the previous comprehensive home care license and began providing laundry services for the residents at the assisted living facility August 1,	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 22 2021. On February 17, 2026, at approximately 1:00 p.m., during the facility tour, the surveyor observed ULP-G providing laundry services for the residents at the facility. ULP-G's employee record contained a cleared background study notice issued by DHS dated June 26, 2020. The licensee's NETStudy 2.0 employee roster printed on February 17, 2026, indicated ULP-D, ULP-E, ULP-F and ULP-G had expired COVID-19 background studies effective December 31, 2022. BACKGROUND AFFILIATION ULP-H ULP-H was hired on September 15, 2021, to provide direct care services for the residents at the facility. ULP-H's employee record included a Background Study (BGS) Clearance letter dated June 5, 2025; however, the background study was affiliated to license number 1076387, a different license owned by the same owners. ULP-I ULP-I was hired on December 7, 2023, to provide direct care services for the residents at the assisted living facility. ULP-I's employee record included a DHS BGS Clearance letter dated December 3, 2023; however, the background study was affiliated to HFID 33367, a different license owned by the same owners.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 23 ULP-J ULP-J was hired on August 13, 2018, to provide direct care services to the residents at the assisted living facility. ULP-J's employee record included a DHS BGS Clearance letter dated July 28, 2021; however, the background study was affiliated to HFID number 33367, a different license owned by the same owners. ULP-H, ULP-I, and ULP-J's records lacked documentation of a cleared background study affiliated with the licensee's current HFID 33366. On February 26, 2026, at 1:47 p.m., the surveyor reviewed the staff list with D-B and verified all employees listed above were active employees of the licensee and provided direct care services for residents. D-O stated some employees worked at both facilities owned by the licensee and should have been affiliated with both license. D-O stated D-O had updated the DHS NETStudy 2.0 employee roster and affiliated ULP-H, ULP-I and ULP-J effective February 17, 2026, after initiation of the survey. D-O stated the licensee would work on getting the employees with expired COVID-19 BGS cleared to work. The licensee's Background Checks policy dated April 30, 2025, indicated all employees as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact would undergo a background study through DHS. Only those with satisfactory results would continue to work with the facility and its residents. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01290	Continued From page 24 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information provided. TIME PERIOD OF CORRECTION: Immediate	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01370	Continued From page 25 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-K).	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01370	Continued From page 26 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 February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B and director (D)-C stated the licensee was aware of the required contents of the employee records; CNS-B managed the nursing content and D-C managed administrative content of employee records. ULP-K was hired on November 25, 2025, to provide direct care services to residents. The licensee's February 2026 monthly staff schedule indicated ULP-K was scheduled to work 20 days out of 28 days. On February 17, 2026, during the course of the survey, ULP-K was observed providing care and services to the residents of the licensee. ULP-K's record lacked evidence of the following: -training on the prevention of falls for providers working with the elderly or individuals at risk for falls; and -understanding the appropriate boundaries between staff and residents and the resident's family. On February 19, 2026, at 10:56 a.m., CNS-B	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01370	Continued From page 27 stated ULP-K's training course transcripts did not indicated ULP-K was assigned or completed the required training noted above. The licensee's Assisted Living Orientation-ULP Staff policy dated April 30, 2025, indicated newly hired ULPs would receive orientation and training topics required by Minnesota statues and rules for assisted living organizations to include the following: -fall prevention; and -appropriate boundaries between staff, resident preferences, cultural background, and family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01380	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-K). 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 February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B and director (D)-C stated the licensee was aware of the required contents of the employee records; CNS-B managed the nursing components and D-C managed administrative components of the employee record. ULP-K was hired on November 25, 2025, to provide direct care services to residents of the facility. The licensee's February 2026, monthly staff schedule indicated ULP-K was scheduled to work 20 days out of 28 days. On February 17, 2026 during the course of the survey, ULP-K was observed providing care and services to the residents of the licensee.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01380	Continued From page 29 ULP-K's record lacked evidence of the following: -range of motion. On February 19, 2026, at 10:56 a.m., CNS-B stated ULP-K's training course transcripts did not indicated ULP-K was assigned or completed training in range of motion. The licensee's Assisted Living Orientation-ULP Staff policy dated April 30, 2025, indicated newly hired ULPs would receive orientation and training topics required by Minnesota statues and rules for assisted living organizations to include training in range of motion. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01440	Continued From page 30 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual had begun working for the licensee for one of one unlicensed personnel (ULP)-K. 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: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living requirements. ULP-K was hired on November 25, 2025, to provide direct care services to residents. The licensee's February 2026, monthly staff	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01440	Continued From page 31 schedule indicated ULP-K was scheduled to work 20 days out of 28 days. On February 17, 2026, during the survey, ULP-K was observed providing care and services to the residents of the licensee. ULP-K's employee record lacked documentation a supervision of ULP-K performing a delegated task within 30 calendar days of providing services had been completed by the registered nurse (RN). On February 19, 2026, at 10:56 a.m., CNS-B stated CNS-B had not completed a 30-day supervisory visit for ULP-K and was not aware of the requirement. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated April 30, 2025, indicated the RN would supervise staff who perform delegated nursing, treatment or therapy services within 30 calendar days after the staff member began working and first perform the delegated resident task. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01470	Continued From page 32 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) 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, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) health impacts related to untreated	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01470	Continued From page 33 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 observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of two employees (clinical nurse supervisor (CNS)-B). 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 February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living requirements. CNS-B was hired April 23, 2025, to supervise and	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01470	Continued From page 34 provide direct care services to residents at the facility. Throughout the survey, CNS-B was observed providing care and services to the licensee's residents. CNS-B's employee record lacked documented evidence of the following required orientation: -overview of the Assisted Living statutes; -handling emergency and using emergency services; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services. On February 18, 2026, at 2:44 p.m., CNS-B send a text to the surveyor indicating CNS-B realized CNS-B had only been assigned and completed annual training courses and had not been assigned new hire orientation to assisted living regulations. CNS-B stated CNS-B recently assigned the required training prior to the start of the survey but had not yet completed. The licensee's Personnel Records policy dated April 30, 2025, indicated the personnel record for each person must include a record of required in-service education for all staff providing services to clients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01530	Continued From page 35 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors 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; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a 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 the initial 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;	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01530	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of three employees (clinical nurse supervisor (CNS)-B, (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure one of three employees (CNS-B) received the required amount of dementia care training in the required time frame. This had the potential to affect all residents and staff. 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: CNS-B CNS-B was hired April 23, 2025, to supervise and provide direct care services to the residents of the licensee. During the course of the survey, February 17, 2026, through February 23, 2026, the surveyor observed CNS-B provide care and services to the residents of the facility. ULP-D ULP-D was hired on June 14, 2018, under the	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01530	Continued From page 37 previous comprehensive home care license and began providing direct care services for the residents at the assisted living facility August 1, 2021. On February 17, 2025, at 10:10 a.m., the surveyor observed ULP-D in the kitchen preparing meals for the residents. At 2:58 p.m., ULP-D stated ULP-D prepared meals and provided direct care for the residents at the facility. CNS-B's record lacked documentation the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. In addition, CNS-B's record indicated CNS-B completed only 2.5 hours of the required eight hours of dementia training within 120 working hours of start date. ULP-D's record lacked documentation the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. On February 19, 2026, at 11:26 a.m., CNS-B stated CNS-B was not aware all employees were required to complete two hours of initial mental illness and de-escalation training by July 1, 2025, and thought it only pertained to new employees. CNS-B verified CNS-B only completed 2.5 hours of dementia training out of the required eight hours. CNS-B stated CNS-B would look for additional dementia training hours CNS-B had completed through a different employer. On February 20, 2026, at 12:27 p.m., CNS-B stated CNS-B was unable to provide additional dementia training transcripts.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01530	Continued From page 38 The licensee's Assisted Living Dementia Training policy dated April 30, 2025, indicated supervisors of direct-care staff would complete a minimum of eight hours initial training on dementia topics within 120 hours of start date. Direct-care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date. The policy did not address mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and 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; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one	01550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01550	Continued From page 39 employee (housekeeping (HSKP)-G) received the required amount of dementia, mental illness, and de-escalation in 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 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 February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. HSKP-G was hired on September 30, 1998, under the previous comprehensive home care license and began providing HSKP services for residents at the assisted living with dementia care facility August 1, 2021. Throughout the survey on February 17, 2026, the surveyor observed HSKP-G completing laundry and housekeeping tasks for the residents at the facility. HSKP-G's employee record lacked evidence HSKP-G completed two hours of initial training on mental illness and de-escalation. On February 19, 2026, at 11:26 a.m., CNS-B stated CNS-B was not aware all employees were required to complete two hours of initial mental illness and de-escalation training by July 1, 2025.	01550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01550	Continued From page 40 The licensee's Assisted Living Dementia Training policy dated April 30, 2025, indicated non-direct care staff would complete a minimum, four hours of initial training on dementia care topic within 120 hours working of the employment start date. The policy did not address mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
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 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;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01620	Continued From page 41 (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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing comprehensive nursing assessments not to exceed every 90 days for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01620	Continued From page 42 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated, CNS-B completed comprehensive resident assessments on admission, 14 days after admission, and then at least every 90 days unless the resident had a change of condition. R2 R2 was admitted to the facility on October 20, 2010. R2's diagnoses included schizophrenia, diabetes, hypertension (high blood pressure), insomnia and mood disorder. R2's Service Plan (Waiver)-Addendum to Contract dated August 5, 2021, indicated R2 received the following services: medication management, blood glucose monitoring, grooming, behavior management, housekeeping, and laundry. On February 19, 2026, at 11:24 a.m., the surveyor observed unlicensed personnel (ULP)-L obtain R2's Dexcom blood glucose meter from the locked kitchen drawer and hand to R2. R2 scanned the Dexcom sensor (blood glucose device that sits under the skin) and obtained a blood glucose reading of 128 millimeters per deciliter (mm/dl).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01620	Continued From page 43 R2's 90-day assessments were completed on August 29, 2025, and December 17, 2025, however, R2's last assessment was due by November 27, 2025 (20 days past due). R3 R3 was admitted to the facility on September 14, 1998. R3's diagnoses included depression, heart failure, dementia, high blood pressure, and schizophrenia. R3's 90-Day Assessment dated September 12, 2025, and December 22, 2025, however, R3's last assessment was due by December 11, 2025 (11 days past due). R4 R4 was admitted to the facility on May 17, 2017. R4's diagnoses included schizophrenia, anxiety, and type two diabetes. R4's Service Plan (Waiver)-Addendum to Contract dated August 18, 2025, indicated R4 received the following services: medication management, blood glucose monitoring, grooming, behavior management, housekeeping and laundry. R4's 90-Day Assessments were completed on October 8, 2025, and January 15, 2026, however, R4's assessment was due by January 6, 2026 (nine days past due). R2, R3, and R4's record lacked evidence of a 90-day reassessment was completed by an RN in the required time frame.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01620	Continued From page 44 On February 20, 2026, at 12:44 p.m., CNS-B stated CNS-B was aware there were resident assessments not completed with the required time frame and it was due to limited time during the holiday season. The licensee's Initial and On-Going Nursing Assessment of residents Under The Comprehensive Licensed Agency policy dated April 30, 2025, indicated the RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: -pre-admission assessment; -14-day assessment: up to 14-days after start of services; -ongoing assessments: completed periodically but no less than every 90-days; and -change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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 45 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 the service plan was revised to reflect current services provided 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 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 February 17, 2026, at 10:16 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. CNS-B stated resident service plans were updated with changes in resident services, a signature was obtained by the resident or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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 46 resident's representative and offered a copy of the updated service plan. R2's diagnoses included schizophrenia, diabetes, hypertension (high blood pressure), insomnia, and mood disorder. On February 19, 2026, at 11:24 a.m., the surveyor observed unlicensed personnel (ULP)-L obtain R2's Dexcom blood glucose meter from the locked kitchen drawer and hand to R2. R2 scanned the Dexcom sensor (blood glucose device that sits under the skin) and obtained a blood glucose reading of 128 millimeters per deciliter (mm/dl). R2's Service Plan (Waiver)-Addendum to Contract dated August 5, 2021, indicated R2 received the following services: medication management, blood glucose monitoring, grooming, daily oxygen saturation monitoring, symptom monitoring, daily skin care, behavior management, housekeeping, and laundry. R2's February 2026 Service Recap Summary, indicated R2 was scheduled and received the following services noted above except the following services: daily oxygen saturation monitoring, daily symptom screening and daily skin cares. R2's prescriber orders dated June 19, 2025, did not include orders for daily oxygen saturation monitoring, skin cares or daily symptom screening. R2's record lacked an updated services plan to reflect current services provided by the licensee. On February 19, 2026, at 2:02 p.m., CNS-B	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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 47 stated CNS-B had updated and printed R2's service plan and it was sitting on CNS-B's desk along with other resident service plans waiting to reviewed by the resident and/or residents' representative and obtain signatures. CNS-B provided the surveyor with R2's unsigned updated service plan effective date August 29, 2025, which did not include daily skin care, saturation monitoring or daily symptom screening. CNS-B stated CNS-B was unaware of any time frame required to update a resident's service plan or obtain appropriate signatures and place in resident records. The licensee's Contents of Service Plans policy dated October 30, 2025, indicated service plans and any revisions to service plans would have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01690	Continued From page 48 standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy and procedure for five of five residents (R4, R5, R8, R9, R10) who received controlled medication storage. 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	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01690	Continued From page 49 portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. CNS-B stated the licensee had residents who received controlled medications (drugs regulated by the government) were double locked in a cupboard and counted every shift by two staff. On February 19, 2026, at 8:43 a.m., the surveyor reviewed the licensee's controlled medication storage with CNS-B, which was double locked in a cabinet in the staff area, and observed the following controlled medication were being stored: -three of R4's methadone 90 milligrams (mg) tablets (used to treat opioid disorder); -25 of R5's lorazepam 2 mg tablets (used to treat anxiety disorders); -21 of R8's lorazepam 5 milligrams (mg) tablets; -two of R9's oxycodone 5 mg tablets (used to treat pain); and -14 of R10's lorazepam 2 mg tables. The surveyor reviewed each resident's Controlled Substance Count Sheets with CNS-B and observed only one staff signature, which indicated resident's controlled medications were only being counted by one staff. CNS-B stated staff were counting the medications at each shift; however, they were not counting with two staff as directed. On February 19, 2026, at 1:54 p.m., unlicensed personnel (ULP)-D stated ULP-D counted residents controlled medications at the beginning of the shift and did not require a second staff	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01690	Continued From page 50 signature to verify accurate count. R4, R5, R8, R9 and R10's controlled medication log records lacked two staff signatures at each change of shift per licensee policy and procedure. The licensee's Controlled Substances/Scheduled II Drugs policy dated April 30, 2025, indicated the licensee's staff, including a licensed nurse whenever possible, would use a preferred practice of counting controlled drugs at the end of each shift if medications were stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty would count the controlled medications together and would document and report any discrepancies immediately to the registered nurse (RN). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01750	Continued From page 51 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of one resident (R2) who received medication management services. 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: R2's diagnoses included schizophrenia, diabetes, hypertension (high blood pressure), insomnia and mood disorder. R2's Service Plan (Waiver)-Addendum to Contract dated August 5, 2021, indicated R2 received the following services: medication management, blood glucose monitoring, grooming, behavior management, housekeeping, and laundry. On February 19, 2026, at 8:18 a.m., the surveyor viewed the locked drawer in the kitchen with unlicensed personnel (ULP)-L and observed an opened pre-filled Lantus (long acting) insulin pen with no prescription label or name on the insulin pen. ULP-L identified the Lantus insulin pen belonging to R2.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01750	Continued From page 52 R2's 90-Day Assessment dated December 17, 2025, indicated staff were to help resident dial up insulin to self-administer. R2's February 2026 Medication Summary indicated R2 was scheduled and received Lantus 46 units under the skin once daily at bedtime, plus two units for priming, for a daily dose of 48 units. R2's medication summary did not include directions R2 was able to sell-administer insulin after setup. On February 19, 2026, at 1:39 a.m., ULP-D and ULP-L stated R2 administered own insulin, ULP-D stated staff dial R2's insulin dose and hand the insulin pen to R2 to self-inject. ULP-L reviewed R2's electronic medication administration record and stated R2's insulin directions did not indicate R2 was able to self-administer own insulin after setup. On February 19, 2026, at 2:02 p.m., CNS-B stated R2 did not have written instructions in R2's medication administration record to indicate R2 was able to self-administer own insulin after setup. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated April 30, 2025, indicated the RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatments, and therapy. The RN would develop written, specific instruction for each client and communicate with the unlicensed personnel about the individual needs of the resident. No further information was provided.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01750	Continued From page 53 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01880	Continued From page 54 On February 17, 2026, at 1:37 p.m., the surveyor reviewed the medication refrigerator with CNS-B observed the internal thermometer temperature reading of 41 degrees Fahrenheit (F). CNS-B stated staff monitor the refrigerator temperatures daily and record results on a monthly calendar. CNS-B was unsure what shift was assigned to record medication fridge temperatures and if staff also recorded temperatures in Residex (web-based health electronic record system). On February 17, 2026, at 4:07 p.m., the surveyor reviewed the licensee's medication refrigerator temperatures recorded on a monthly calendar and observed the following: -December 2025 lacked 8 out of 31 missed opportunities to record temperatures; -January lacked 6 out of 31 opportunities; and -February lacked 2 out of 17 opportunities. On February 20, 2026, at 1:32 p.m., CNS-B verified there were missed days each month staff had not recorded the medication refrigerator temperatures. CNS-B stated CNS-B set up a task for ULPs in Residex to monitor and record medication fridge temps twice a day to ensure daily temperature monitoring was completed. On February 23, 2026, at 10:02 a.m., CNS-B sent the medication refrigerator content to the surveyor via email. The following medications were documented being stored by the licensee: -R2's 15 unopened Novolog (rapid-acting) and seven unopened Lantus (long-acting) pre-filled insulin pens; and -R9's unopened bottle of latanoprost (used for increased eye pressure) 0.005% eye drops. The licensee's manufacturer instructions for Novolog insulin dated 2000, indicated to store	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01880	Continued From page 55 unopened Novolog in the refrigerator between 36 F to 46 F. Do not allow Novolog to freeze. The licensee's manufacturer instructions for Lantus insulin dated August 2022, indicated to store unopened Lantus insulin in the refrigerator between 36 F to 46 F. Do not allow Lantus to freeze. The manufacturer's instructions for use of latanoprost eye drop dated August 2011, indicated to store unopened bottle(s) under refrigeration between 36 F to 46 F. The licensee's Storage of Medications policy dated April 30, 2025, indicated medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 medications were maintained bearing the original prescription label with information regarding the direction for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 56 use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. In addition, the licensee failed to ensure medications were maintained to include the opened date and expiration date for time sensitive medications stored by the licensee in one of one medication storage cabinets and failed to monitor for expired medications being managed and stored by the licensee. 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: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility. On February 17, 2026, at 1:27 p.m., the surveyor reviewed the medication cart with CNS-B and observed the following: -a white small, sealed envelope dated December 23, 2025, through December 25, 2025, labeled with R11's hydroxyzine (used to treat anxiety and severe itching); and -a small white envelope dated December 23, 2025, through December 28, 2025, labeled with R11's buspirone 10 mg one tablet as needed for anxiety. CNS-B stated the envelopes where from when	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 57 R11 went on leave from the facility and returned with the envelopes with untaken medications. CNS-B stated the licensee did not have a system in place to destroy resident medications. KITCHEN DRAWER On February 19, 2026, at 8:08 a.m., the surveyor reviewed a locked kitchen drawer where additional resident medications were being stored with unlicensed personnel (ULP)-L and observed the following: -R2's opened Lantus pre-filled insulin pen lacked the date the insulin had been opened and when the insulin would expire. In addition, R2's Lantus insulin lacked a prescription label bearing the resident name; -R5's opened bottle of polyvinyl alcohol (Systane) 1.4% lubricating eye drop had expired December 2025; -R9's opened bottle of dorzolamide-timolol eye drop (used to treat increased eye pressure) lacked the date the eye drop was opened and when the eye drop would expire; -R11's two opened budesonide-formoterol inhalers lacked the date the inhalers had been opened and when the inhalers would expire; and -R12's opened budesonide-formoterol (Symbicort) inhaler lacked the date the inhaler had been opened and when the inhaler would expire. MEDICATION STORAGE CABINET/EXPIRED MEDICATIONS/NO PRESCRIPTION LABELS On February 19, 2026, at 8:25 a.m., the surveyor reviewed the medication storage cabinet in the staff area with CNS-B and observed the following expired medications stored by the licensee: -an opened bottle of facility stock Tums expired January 2026; -an opened bottle of liquid Imodium expired	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 58 February 2021; -an opened bottle of Tums expired November 2025; -an opened bottle of pain reliever tablets expired December 2021; -two opened boxes of Pepto-Bismol chewable tables expired May 2024; and -open container of allergy relief tablets expired March 2024. During the medication cabinet observation, CNS-B stated the following medications were not included on the facility standing orders and CNS-B was unable to identify any resident currently taking or had taken the following medications being stored in the medication cabinet: -an opened bottle of Day Quil lacked a prescription label or name of a resident; -an opened box of Day Quil tablets lacked a prescription label or name of a resident; and -an opened box of soft gels Gas X. On February 20, 2026, at 3:53 p.m., registered nurse (RN)-B stated the ULP assigned to the medication cart went through the medication carts every Monday and Thursday looking for expired medications and the nurses complete routine audits. CNS-B stated when insulin, eye drops, inhalers, creams, bottles of medications were opened, staff have been instructed to put the date the medications had been opened and for time-sensitive medications, put the date the medication would expire. The manufacturer's instructions for use of Lantus dated June 2022, indicated to discard the Lantus insulin pen 28 days after opening, even if the insulin pen still contains Lantus.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 59 The manufacturer's instructions of use of polyvinyl alcohol (Systane) 1.4% lubricating eye drop dated July 2009, indicated to throw away the bottle 28 days after opening. The manufacturer's instructions for use of dorzolamide/timolol eye drops dated January 2020, indicated to use within 28 days after opening the bottle. The manufacturer's instructions for use of budesonide/formoterol (Symbicort) inhaler dated December 2011, indicated to discard the Symbicort inhaler three months after the removal of its foil package. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01890		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01910	Continued From page 60 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 record all of the required content in the disposition of medications for one of one resident (R1) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated CNS-B did not document medications returned to the pharmacy and CNS-B had not disposed of any medications since starting in April 2025 and was trying to figure out the process and procedure for destroying medications. CNS-B stated all medications no longer used by residents were stored in a locked cabinet in CNS-B's office waiting to be destroyed. CNS-B had not documented inventory of residents medications waiting to be destroyed.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01910	Continued From page 61 R1's diagnoses included schizophrenia, anxiety, bi-polar, paranoid delusions, visual hallucination, and suicidal thoughts. R1's undated Discharge/Transfer Summary indicated R1's services began August 2, 2022, and was discharged on December 23, 2025. R1's discharge summary lacked a complete summary of R1's care and services provided by the licensee including the disposition of R1's medications at the time of discharge. R1's December 2025, Medication Administration Summary indicated R1 was scheduled and received the following medications: -alprozolam 1 milligram (mg)-take ½ tablet at 8:00 a.m., 2:00 p.m., and one tablet at bedtime for anxiety; -fluphenazine 10 mg ½ tablet twice a day used to treat schizophrenia; -lamotrigine 150 mg one tablet twice a day used to treat bipolar; -meloxicam 15 mg one tablet daily with food used to treat inflammatory diseases; -tab-a-vite one tablet daily used for supplementation; -Invega Sustenna 234 mg 1.5 milliliters injection every three weeks used to treat schizophrenia; and -methocarbamol 750 mg one tablet four times a day as needed for muscle relaxant. R1's record lacked documentation of R1's disposition of medications at discharge. The licensee's Disposition or Disposal of Medication policy dated April 30, 2025, indicated when resident's medications were stored by the licensee, the medication would be given to the resident or resident's representative when the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01910	Continued From page 62 resident's medication management services were terminated. Staff would document in the residents' record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medications remaining. Disposal of unused or discontinued prescription drugs managed by the licensee would documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01950	Continued From page 63 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R2) who received treatment and therapy services. 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: During the entrance conference on February 17, 2026, at 10:16 a.m., licensed assisted living director (LALD)-A stated the licensee provided blood glucose monitoring for residents of the licensee. Clinical nurse supervisor (CNS)-B stated the majority of the residents checked their own blood glucose under the supervision of staff. R2's diagnosis included diabetes. On February 19, 2026, at 11:24 a.m., the surveyor observed unlicensed personnel (ULP)-L obtain R2's Dexcom blood glucose meter (a continuous glucose monitoring (CGM) system that tracks blood sugar levels in real time) from	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01950	Continued From page 64 the locked kitchen drawer and handed to R2. R2 scanned the Dexcom sensor (blood glucose device that sits under the skin) and obtained a blood glucose reading of 128 millimeters of mercury (mmHg). ULP-L recorded R2's blood glucose results in R2's electronic medical record. R2's Service Plan (Waiver)-Addendum to Contract dated August 5, 2021, indicated R2 received the following services: medication management, blood glucose recording, grooming, behavior management, housekeeping, and laundry. R2's Care Plan dated January 22, 2026, included blood glucose monitoring four times a day and to wear gloves, follow agency policy, check blood glucose and record. Notify nurse if blood glucose reading was below 70 mmHg or consistently above 300 mmHg. R2's Treatment Recap Summary February 2026, indicated R2 was scheduled and received blood glucose monitoring four times a day. R2's Individualized Treatment and Therapy Plan dated September 21, 2018, included blood glucose monitoring four times a day, for staff to wear gloves and follow agency protocol, check blood glucose and record. Notify nurse if blood glucose was below 70 mmHg or consistently over 300. R2's record did not include specific, written instructions R2 had a Dexcom blood glucose meter and was able to monitor own blood glucose under the supervision of staff. On February 19, 2026, at 12:44 p.m., CNS-B stated R2 was able to monitor own blood glucose	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
01950	Continued From page 65 and report reading to ULPs and document in R2's record. CNS-B stated R2's instructions did not indicate the correct method of monitoring R2's blood glucose with the use of Dexcom monitor or R2 was able to monitor own under supervision of ULPs. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated April 30, 2025, indicated the RN may delegate to unlicensed personnel administration of medications, treatment and therapy if the unlicensed personnel had satisfied the training requirements. The RN would develop written specific instruction for each client. Treatment or Therapy Management Services policy dated March 21, 2023, indicated after assessment or orders received for treatment or therapy services, the licensed nurse would develop and maintain a current individualized treatment and therapy management plan for each resident to include: -a statement of the type of treatment or therapy services would be provided; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy in an effort to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
03090	Continued From page 66 (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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: During the entrance conference on February 17, 2026, at 10:16 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 17, 2026, from 12:54 p.m., to 1:27 p.m., the surveyor toured the facility with LALD-A and director (D)-C and did not observe signage to disclose electronic monitoring. LALD-A stated the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD BROOKSTON, MN 55711

(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
03090	Continued From page 67 licensee did not have electronic monitoring within the building, so the LALD-A did not think the license was required to post electronic monitoring signage. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN 55711
St Louis County
Parcel:

Phone: 218-878-0642
brad@petersoncolonialhomes.com

License Info

License: HFID 33366
Brad Eckel
Risk:
License:
Expires on:
CFPM: Myiah Williams
CFPM #: 56563; Exp: 2/25/2028

Inspection Info

Report Number: F7983261028
Inspection Type: Full - Single
Date: 2/17/2026 Time: 10:20:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT:
GROUND BEEF WAS STORED ABOVE YOGURT IN THE AVANTCO SINGLE-DOOR UPRIGHT REFRIGERATOR IN THE DRY STORAGE AREA. IT WAS MOVED TO THE BOTTOM OF THE AVANTCO DOUBLE-DOOR UPRIGHT REFRIGERATOR.
Comply By: Complied On Site Originally Issued On: 2/17/2026

! **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:
STRING CHEESE AND MILK IN THE SELF-SERVE DISPLAY REFRIGERATOR WERE 47 F. AND 46 F. RESPECTIVELY. THEY WERE DISCARDED. DISCUSSED USING THIS UNIT FOR NON-TCS FOOD (FOOD THAT DOESN'T NEED REFRIGERATION). BE SURE THAT THE REFRIGERATOR CAN KEEP FOOD AT 41 F. OR LOWER BEFORE USING IT FOR THE STORAGE OF TCS FOOD.
Comply By: Complied On Site Originally Issued On: 2/17/2026

New Order: 4-200 Equipment Design and Construction
4-203.12 *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.
COMMENT:
THE EXTERNAL DIGITAL TEMPERATURE DISPLAY FOR THE SELF-SERVE DISPLAY REFRIGERATOR INDICATED A TEMPERATURE OF 34 F. AIR TEMPERATURE INSIDE OF THE UNIT WAS 41 F. PLACE AN ACCURATE THERMOMETER INSIDE OF THE UNIT IF IT IS GOING TO BE USED TO STORE TCS FOOD.
Comply By: 2/17/2026 Originally Issued On: 2/17/2026

Food & Beverage General Comment

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed, and cooling.

2) Provided an illness reporting fact sheet, an employee illness decision guide, an employee illness log, a vomit cleanup poster, a temperature requirement fact sheet, and a cooling fact sheet.

3) Domestic refrigerators have been replaced with commercial (ANSI) refrigerators.

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 Duluth District Office inspection report number F7983261028 from 2/17/2026

Tammie Johnson
Person in Charge

Gary Collyard,
Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Peterson Colonial Homes 2
Brookston
County/Group: St Louis County

Inspection Info

Report Number: F7983261028
Inspection Type: Full
Date: 2/17/2026
Time: 10:20:00 AM

Food Temperature: Product/Item/Unit: String Cheese**; Temperature Process:** Cold-Holding
Location: Self-Serve Display Refrigerator at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Self-Serve Display Refrigerator at 46 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Rice Hot Dish**; Temperature Process:** Cold-Holding
Location: Arctic Air Single-Door Upright Refrigerator at 40 Degrees F.
Comment: Kitchen.
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Air**; Temperature Process:** Cold-Holding
Location: Countertop Milk Refrigerator at 39 Degrees F.
Comment: Kitchen.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salmon**; Temperature Process:** Cold-Holding
Location: Avantco Double-Door Upright Refrigerator at 41 Degrees F.
Comment: Hallway.
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Air**; Temperature Process:** Cold-Holding
Location: Avantco Single-Door Upright Refrigerator at 38 Degrees F.
Comment: Dry storage area.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Left Avantco Double-Door Upright Freezer at -7 Degrees F.
Comment: Dry storage area.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Right Avantco Double-Door Upright Freezer at -4 Degrees F.
Comment: Dry storage area.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Turkey in Soup**; Temperature Process:** Cooking
Location: Stovetop at 181 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Air**; Temperature Process:** Cold-Holding
Location: Self-Serve Display Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Utensil Surface Temperature**; Temperature Process:** Warewashing
Location: Warewashing Machine at 160 Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN 55711
St Louis County
Parcel:

Phone: 218-878-0642
brad@petersoncolonialhomes.com

License Info

License: HFID 33366
Brad Eckel
Risk:
License:
Expires on:
CFPM: Myiah Williams
CFPM #: 56563; Exp: 2/25/2028

Inspection Info

Report Number: F7983261034
Inspection Type: Follow-up - Single
Date: 2/26/2026 Time: 9:55:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

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 Duluth District Office inspection report number F7983261034 from 2/26/2026

Tammie Johnson
Person in Charge

Gary Collyard,
Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Peterson Colonial Homes 2
Brookston
County/Group: St Louis County

Inspection Info

Report Number: F7983261034
Inspection Type: Follow-up
Date: 2/26/2026
Time: 9:55:00 AM

Equipment Temperature: Product/Item/Unit: Air**; Temperature Process:** Cold-Holding
Location: Self-Serve Countertop Refrigerator at 40 Degrees F.
Comment: Replacement of the display unit.
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL33366016-0	**Date:** 2/23/2026
Facility Name: Peterson Colonial Homes 2	
Facility Address: 4723 Hygard Road, Brookston, MN 55711	

☒ **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. 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 egress path to the emergency exit door on the back of the building was used for storage of pet supplies, including a gate and crate.

3. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments:
   - In the designated outdoor smoking areas, burnt cigarettes had been discarded on the ground and on the wood decks. Disposal containers were provided in these areas.
   - Two burnt cigarettes had been discarded of on a wall ledge in occupied resident room 21.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring. Extension cords shall not be extended under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments:
   - An extension cord was used to supply power to office equipment. This extension cord extended under the back office door.
   - Extension cords were used to supply power to personal electronics in resident rooms 12, 15, and 18.

5. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: A power strip was plugged into an extension cord in the smoking room.

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: Carbon monoxide alarms were not installed within ten feet of all resident bedrooms.

7. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: Weatherproof covers were missing from several exterior electrical outlets.

8. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 503.5.3]

   Comments: One oxygen cylinder was not stored in a rack or holder in the employee office.

☒ **TAG IDENTIFICATION: 0780**

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

---

1. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarms were not installed outside all resident bedrooms.

2. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: When the smoke alarms were tested by the licensee, all dwelling unit smoke alarms were not actuated.

☒ **TAG IDENTIFICATION: 0800**

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

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:
   - One wall tile was missing in the shared bathroom across from resident room 1.
   - There was water damage on the ceiling and peeling paint in occupied resident room 2.
   - There was a hole in the wall behind the door in unoccupied resident room 10.
   - In occupied resident room 21, the flooring was in disrepair, and the light covers were missing. The licensee stated new flooring had already been ordered and the resident had removed the covers.
   - Light covers were missing in the smoking room and on one second floor wall fixture.

☒ **TAG IDENTIFICATION: 0810**

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

---

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The emergency evacuation floor plan inappropriately labeled a dog gate and crate area in front of an exit door.

2. 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: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the past twelve months from the licensee. Documentation for emergency preparedness training in November 2025 was provided. The licensee stated this training included the FSEP. The licensee failed to conduct site specific FSEP training with employees at least twice per year and properly document this training.

3. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for resident fire safety and evacuation training completed in the past twelve months from the licensee. Documentation was provided for resident training on fire

safety and evacuation completed on December 17, 2024. Resident training was not completed in the last year.