Electronically Delivered

October 22, 2026

Licensee
Lange Board and Room Inc
13892 37th Street
Clear Lake, MN 55319

RE: Project Number(s) SL36378016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(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: SL33606016-0 On September 14, 2026, through September 17, 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 29 resident(s); all of whom were receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 15, 2026, issued for SL336016-0, tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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 of Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice a year. In addition, the licensee failed to ensure the staffing schedule was posted as required. This had the potential to affect all 29	0 470		

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0 470	Continued From page 2 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2026, at 10:12 a.m., surveyor asked licensed assisted living director (LALD)-C to direct surveyor to the required postings. LALD-C showed surveyor where the postings should be located and stated, "[clinical nurse supervisor (CNS)-D] was working on the schedule, and she did not finish it, so it is not posted anywhere. I know her and [administrator/unlicensed personnel (A/ULP)-H] go over the staffing schedule, but we don't have anything formally written up. I don't think we have MAARC posted anywhere it seems. I know we don't have the license posted at the cottage, or any of these missing items." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 3 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 5	0 510		
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 maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control, by not cleaning shared equipment, for two of two employees (unlicensed personnel (ULP)-B and ULP-G) observed completing medication administration. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B began employment with the licensee and	0 510		

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0 510	Continued From page 6 started providing assisted living services March 27, 2026. On September 16, 2026, at 11:32 a.m., ULP-B was observed to take a shared oximeter monitor from the medication administration room desk and without cleaning it, use it to obtain resident (R3) oxygen, and pulse. ULP-B without cleaning the monitor placed the monitor back in the desk drawer. ULP-G began employment with the licensee and started providing assisted living services September 5, 2009. On September 15, 2026, at 11:28 a.m., ULP-G was observed to take a shared oximeter monitor from the medication administration room desk and without cleaning it, use it to obtain R3's oxygen, and pulse. ULP-G without cleaning the monitor placed the monitor back in the desk drawer. On September 16, 2026, at 12:22 p.m., ULP-B stated, "[The oximeter monitor] is used on other residents, I don't clean it, I don't know when or if it gets cleaned." On September 17, 2026, at 11:09 a.m., clinical nurse supervisor (CNS)-D stated, "After each use between patients, any shared equipment needs to be cleaned. We will do some re-education." The licensee's Cleaning and Disinfecting Vital Sign Equipment policy, dated August 1, 2021, indicated, "All vital sign equipment, thermometers, blood pressure machines, oximeters, stethoscopes should be sanitized after every use with a Clorox wipe for infection control in between residents."	0 510		

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0 510	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to its grievance procedure, with all required content. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	0 550		

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0 550	Continued From page 8 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting at the second building called "The Cottage" to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances. On September 15, 2026, at 10:12 a.m., surveyor asked licensed assisted living director (LALD)-C to direct surveyor to the required postings. LALD-C showed surveyor where the postings should be located and stated, "[clinical nurse supervisor (CNS)-D] was working on the schedule, and she did not finish it, so it is not posted anywhere. I know her and [administrator/unlicensed personnel (A/ULP)-H] go over the staffing schedule, but we don't have anything formally written up. I don't think we have MAARC posted anywhere it seems. I know we don't have the license posted at the cottage, or any of these missing items." The licensee's Complaint Policy and Procedure policy dated October 9, 2023, indicated, "Residents, designated representatives, families, and other stakeholders have a system to report a complaint regarding services provided or other situations related to the facility. The policy will be posted in a conspicuous location." No further information was provided.	0 550		

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0 550	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display its current assisted living license in all of the main entrance of the facility campus. This had the potential to affect all residents, staff and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the licensee's assisted living license to be posted at the second building called "The Cottage". On September 15, 2026, at 10:12 a.m., surveyor asked licensed assisted living director (LALD)-C to direct surveyor to the required postings. LALD-C showed surveyor where the postings should be located and stated, "[clinical nurse supervisor (CNS)-D] was working on the	0 570		

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0 570	Continued From page 10 schedule, and she did not finish it, so it is not posted anywhere. I know her and [administrator/unlicensed personnel (A/ULP)-H] go over the staffing schedule, but we don't have anything formally written up. I don't think we have MAARC posted anywhere it seems. I know we don't have the license posted at the cottage, or any of these missing items." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors.	0 580		

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0 580	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2026, at 1:50 p.m., licensed assisted living director (LALD)-C presented surveyor with meeting minutes indicating the last meeting was completed in November of 2025. LALD-C stated, "this is all we have, we have not done anymore since these." The licensee's Quality Management Plan policy, dated November 8, 2024, indicated, "1. The Assisted Living Director will establish a quality management program to develop and maintain the agency's continuous performance improvement efforts. 2. The Assisted Living Director will establish a Quality Council made up of key staff to develop and implement the agency's quality management program. 3. The Quality Council meetings will be held at least quarterly to evaluate the quality of care. 4. Data and information evaluated by the Quality Council will include at a minimum: a. Complaints and feedback from residents, residents' representatives, residents' families and agency staff; b. Other relevant information. c. Resident services d. Staffing - to determine if staffing changes are	0 580		

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	33606	A. BUILDING: _____ B. WING _____	09/18/2026

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0 580	Continued From page 12 needed to ensure safe and competent resident services e. Vulnerable Adult reports to the Common Entry Point; f. Incident reports; g. Medication errors; h. Results of audits of resident records; i. Results of audits of personnel files; j. Results of MDH regular surveys and OHFC surveys of our agency 5. Minutes of the Quality Council meetings will be summarized for all staff to review and these summaries will be available 6. Quality Council meeting minutes will be retained for two-years and will be made available to the commissioner at the time of survey, investigation, or renewal." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) This had the potential to affect all 29 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 15, 2026, at 10:12 a.m., surveyor asked licensed assisted living director (LALD)-C to direct surveyor to the required postings, the surveyor observed the facility's main entry area and common areas lacked the required posted information as followed: - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On September 15, 2026, at 10:12 a.m., LALD-C states, "[clinical nurse supervisor (CNS)-D] was working on the schedule, and she did not finish it, so it is not posted anywhere. I know her and [administrator/unlicensed personnel (A/ULP)-H] go over the staffing schedule, but we don't have anything formally written up. I don't think we have MAARC posted anywhere it seems. I know we	0 640		

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0 640	Continued From page 14 don't have the license posted at the cottage, or any of these missing items." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650		

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0 650	Continued From page 15 records included all required content for one of two employees (unlicensed personnel (ULP)-B with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B began employment with the licensee and started providing assisted living services March 27, 2026. On September 16, 2026, at 11:32 a.m., ULP-B was observed to prime and waste R3's insulin pen with two units, ULP-B then handed the insulin pen to R3 and observed R3 to dose up the correct amount of units scheduled and observed R3 administer the insulin. ULP-B employee record lacked documentation of insulin pen training. On September 16, 2026, at 12:23 p.m., ULP-B stated, "I was trained by the nurse on what to do, but we do not actually administer it we just supervise them and make sure they are doing it right." On September 16, 2026, at 12:47 p.m., clinical nurse supervisor (CNS)-D stated, "I was told the aides are not allowed to give insulin so this is what we do instead, she was trained, I just don't	0 650		

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0 650	Continued From page 16 have it documented." The licensee's Care Fundamentals - Management Guide dated August 28, 2024, indicated all staff training records would be kept in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which	0 660		

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0 660	Continued From page 17 included a current facility TB risk assessment. 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: On September 14, 2026, at 1:50 p.m., licensed assisted living director (LALD)-C presented surveyor with the facility TB risk assessment worksheet for health care settings licensed by Minnesota Department of Health dated September 3, 2024. LALD-C stated, "this is all we have, we have not done anymore since these." The Licensee's Exposure to Tuberculosis policy dated August 22, 2023, indicated, "Healthcare facilities must develop a written TB exposure control plan based on a risk assessment of TB among patients and healthcare workers in each facility." The Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019 dated May 16, 2019, indicated all health care personnel should have a baseline TB screening including an individual risk assessment. No further information was provided.	0 660		

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0 660	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated October 14, 2024, lacked evidence of the following required content: -Have a policy and procedure for the use of volunteers in an emergency, including a staffing emergency. Facilities must address their ability to respond to a surge in residents; and -Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and including a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise, and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On September 15, 2026, at 10:57 a.m., licensed assisted living director (LALD)-C acknowledged the above-mentioned items were missing and stated, "No I have never thought about the use of volunteers in an emergency." When asked if the licensee had any drills other than fire drills LALD-C stated, "No, none that have been done recently, none in the last year." No further information was provided.	0 680		

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0 680	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents personal health and medical information was kept private. This had the potential to affect all 29 residents This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, from 11:09 a.m. to 11:56 a.m., surveyor observed the unlicensed personnel (ULP)-G walk away from the charting computer to	0 700		

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0 700	Continued From page 21 attend to other tasks in another area of the facility multiple different times. The computer screen was left open displaying residents medical information. The surveyor observed four residents and two staff that were not responsible for medications, pass directly by the unattended laptop that was located in an open and accessible medication administration office. On On September 15, 2026 from 7:36 a.m., to 7:45 a.m., surveyor observed administrator/unlicensed personnel (A/ULP)-H walk away from the charting computer to attend to other tasks in another area of the facility two different times. The computer screen was left open displaying residents medical information. The surveyor observed two resident, near the unattended laptop that was located in an open and accessible medication administration office. On September 17, 2026, the clinical nurse supervisor (CNS)-D stated, "Ok so we have talked about this before. They are taught to shut the door to the medications once they are done passing medications, but they leave it open until all the medications are passed. So even though they are right there in the next room and going back and forth they need to shut that door each time going forward? Same thing with closing down the screen to the computer, they shut it down after all the medications are passed." The Licensee's Resident Record Requirements policy dated January 1, 2022, indicated, "The Licensed Assisted Living Director and the CNS will determine where records are kept depending upon whether or not a resident is receiving clinical services." However, the policy did not indicate that resident records would be kept private.	0 700		

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0 700	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 23 Days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in	0 780		

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0 780	Continued From page 24 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 780		
0 800 SS=F	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	0 800		

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0 800	Continued From page 25 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 16, 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=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

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

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0 810	Continued From page 27 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 September 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 28 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01060		

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01060	Continued From page 29 R4 was admitted to the licensee and began receiving assisted living services on June 30, 2021. R4's signed Service Plan, dated August 12, 2026, indicated R4 received services including assistance with medication administration, grooming, housekeeping, laundry, behavior management, bathing, and safety checks and vitals. R4's Resident Notes dated July 6, 2026, to August 6, 2026, indicated R4 had been admitted to a transitional care unit on July 6, 2026, and R4 had not returned to the facility until August 6, 2026. R4's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the Office of Ombudsman for Long-Term Care with in four days that R4 had been relocated and had not	01060		

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01060	Continued From page 30 returned to the facility. On September 14, 2026, at 12:43 p.m., licensed assisted living director (LALD)-C stated, "For the past couple of people I am pretty sure we have missed that step and we have not sent out the forms to the Ombudsman." Clinical nurse supervisor (CNS)-D stated, "We did not, I am fairly new so there is going to be some things I may have missed. I know I didn't send one for [R4]." LALD-C then stated, "I am not going to lie, we are probably missing ninety percent of them to the Ombudsman." The Licensee's Emergency Relocation policy dated August 27, 2024, indicated, "When a facility enacts an emergency relocation, the facility must deliver, as soon as practicable, a written notice to the resident, their legal representative and their designated representative. The notice must be delivered to the resident's case manager if the resident is receiving home and community-based waiver services. The notice must also be delivered to the Office of Ombudsman for Long Term Care as soon as practicable and within 24 hours if the resident has relocated and not returned to the facility within four days." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01430 SS=D	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify	01430		

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01430	Continued From page 31 that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel for one of one employees (ULP-B) records reviewed. This had the potential to affect all three residents. 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: ULP-B began employment with the licensee and	01430		

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01430	Continued From page 32 started providing assisted living services March 27, 2026. On September 16, 2026, at 11:32 a.m., ULP-B was observed to take a shared oximeter monitor from the medication administration room desk and without cleaning it, use it to obtain R2's oxygen, and pulse. ULP-B without cleaning the monitor placed the monitor back in the desk drawer. ULP-B's employee record lacked documentation of direct supervision to verify she performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On September 16, 2026, at 12:41 p.m., licensed assisted living director (LALD)-C stated, "stated I don't have supervision for her; I don't even have a job description for [ULP-B] I don't know why I just did not do one for her. My normal practice is to have the nurse do them within 30 days." The licensee's Supervision of Unlicensed Personnel policy, dated February 10, 2025, indicated, "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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01430		

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

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01500	Continued From page 34 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on October 29, 2024, to perform direct care services to residents.	01500		

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01500	Continued From page 35 On September 14, 2026, at 11:37 a.m., surveyor observed ULP-E assisting residents with lunch. ULP-E's employee records lacked evidence annual training had been completed as required in the following areas: -Assisted Living Bill of Rights. On September 17, 2026, at 11:15 a.m., licensed assisted living director (LALD)-C stated, "When we started with Rtasks (an electronic charting system) we did new education, they just push it out each month when things are due, and they are spaced out throughout the year, so they are done within the year, but it is done on their schedule. I have on the dashboard where I can check that, to make sure they do it on time, but I will be honest that is something I have not been doing it." The licensee's Orientation an Annual Training Requirements policy, dated January 1, 2022, indicated, "All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services." The policy also indicated that the annual training would include training on the home care bill of rights, and did not mention the assisted living bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01880	Continued From page 36	01880		
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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 14, from 11:09 a.m. to 11:56 a.m., surveyor observed maintenance (M)-F enter the medication room where all medications for 29 residents were stored, to grab a key from the master key storage box located directly behind the door of the secured medication room. M-F was not responsible for medication administration. M-F then exited the medication room leaving the door opened and unsecure. Unlicensed personnel (ULP)-G then walked into the medication room and grabbed a container of medications and walked away from the	01880		

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01880	Continued From page 37 medication room to attend to other tasks in another area of the facility. ULP-G was observed to do this multiple different times, leaving the medication room unlocked and unattended. The surveyor observed two staff that were not responsible for medications, pass directly by the unattended and unsecured medication room. On On September 15, 2026 from 7:36 a.m., to 7:45 a.m., surveyor observed administrator/unlicensed personnel (A/ULP)-H walk away from the medication room to attend to other tasks in another area of the facility two different times. The the medication room was left unlocked and unattended. On September 16, 2026, at 12:50 a.m., clinical nurse supervisor (CNS)-D stated, "Ok so we have talked about this before. They are taught to shut the door to the medications once they are done passing medications, but they leave it open until all the medications are passed. so even though they are right there in the next room and going back and forth they need to shut that door each time going forward? Same thing with closing down the screen to the computer, they shut it down after all the medications are passed." The licensee's Medication Management for Management (Training) policy, dated January 1, 2022, indicated, "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." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 38 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 time sensitive medications were dated when opened for one of one residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee and began receiving assisted living services on August 18, 2025. R3's diagnoses included paranoid schizophrenia. R3's signed Service Plan, dated June 11, 2026, indicated R3 received services including	01890		

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01890	Continued From page 39 assistance with dressing, medication administration, meal reminders, peri care, blood glucose monitoring, housekeeping, laundry, behavior management, bathing, and safety checks and vitals. On September 15, 2026, at 11:28 a.m., surveyor observed unlicensed personnel (ULP)-G to administer medications to R3. ULP-G retrieved a Novolog insulin pen from the medication room from a drawer labeled with R3's name and assisted R3 with insulin. R3's insulin pen lacked a label to identify the date the insulin pen was opened and the date the insulin pen would expire. On September 15, 2026, at 11:31 a.m., surveyor inquired how ULP-G would know the insulin pen was not expired and safe to use for R3. ULP-G stated, "I don't know I guess the pen should be dated. I didn't know, none of our insulin pens have dates on them. If it is in the bin then it's good, he gets it every day." On September 16, 2026, at 12:52 p.m., clinical nurse supervisor (CNS)-D stated, "Ok so we will need to make sure that all the insulin pens get dated upon opening and I am not sure why the eye drops are not in the original box, it must have gotten thrown away, we will have to find another solution." The licensee's Medication Management for Management (Training) policy, dated January 1, 2022, indicated, "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."	01890		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(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 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three residents (R5) with consumer bed rails and assistive devices. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 had diagnoses to include diabetes mellitus, anxiety, major depressive disorder, and hypertension.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 R5's signed Service Plan dated May 16, 2026, indicated R5 received bathing assistance, compression stockings, denture care, dressing, hearing aids, housekeeping, toileting, laundry, vitals, and medication administration. On September 15, 2026, at 8:15 a.m., the surveyor observed R5's bed cane bed rail (consumer bed rail) at the top of the bed on left side of the bed when standing at the head of the bed looking at the foot of the bed. The bed rail was firmly attached to the bed. Licensed practical nurse/licensed assisted living director (LPN/LALD)-C stated, "[R5] uses a bedrail, and I am going to be honest when [clinical nurse supervisor (CNS)-D] was looking for the device assessment, she wasn't sure what that even meant so I am guessing we don't have an assessment for it." R5's 90-day assessment dated August 39, 2026, indicated R5 did not have bed rails. R5's record lacked: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 42 On September 16, 2026, at 10:37 a.m., clinical nurse supervisor (CNS)-D stated, "We have a few bed canes ordered from the providers, we work with the resident on how to safely use them, for [R5], I guess I didn't even realize we had to do one, I guess now that I think about it, (9a blank assessment) is in there, but I didn't even think to do the assessment when we put the [bedrail] in." The Food and Drug Administration (FDA) guidance A Guide to Bed Safety dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

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02310	Continued From page 43 improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Devices and Device Assessment - Bed Rail Use dated November 18, 2024, indicated, '1. If the resident expresses the desire to use a device or a device is in use /recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and / or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident '	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 44 s record to include: a. Results of the assessment b. Discussion with resident/responsible party regarding risks and benefits and alternatives considered / recommended c. Decision made/outcome of discussion. 5. Staff will be educated to report to a licensed nurse immediately if the device is found to be loose or malfunctioning. 6. Physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Director of Health Services, or Housing Director will be notified immediately. 7. Maintenance staff will inspect bed and mattress for zone safety on a monthly basis. 8. Maintenance staff will inspect bed devices monthly. If the device has become loose/unstable in any way it will be removed and the responsible party will be notified. Maintenance is to attempt to secure the device and if unable remove it and notify the responsible party. 9. Two times per year the Clinical Nurse Supervisor, or designee, will check the FDA website for recalls on bed assistive devices. The CNS is enrolled in a product recall email list as well. 10. If a licensed nurse, or other designee believes that the assistive device places the resident at risk for harm (EX: Unable to use safely etc) it will be removed and the family will be notified.' No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Food & Beverage Inspection Report

Establishment Info

Lange Board and Room LLC
13892 37th St
Clear Lake, MN 55319
Sherburne County
Parcel:

Phone:
jessica.iten@langebr.org

License Info

License: HFID 33606

Risk:
License:
Expires on:
CFPM: JESSICA ITEN
CFPM #: 9930; Exp: 10/7/2029

Inspection Info

Report Number: F1037261280
Inspection Type: Full - Single
Date: 9/16/2026 Time: 10:51:57 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-800 Highly Susceptible Population**
3-801.11C *Priority Level: Priority 1 CFP#: 26*
MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.
COMMENT: DISCONTINUE OFFERING UNDERCOOKED EGGS, SUCH AS OVER EASY OR SUNNY SIDE UP EGGS. DISCUSSED OBTAINING PASTEURIZED EGGS PRIOR TO OFFERING EGGS COOKED TO ORDER. UNTIL PASTEURIZED EGGS ARE PROVIDED, EGGS MUST ONLY BE OFFERED FULLY COOKED (145 DEG F / NO RUNNY WHITES OR RUNNY YOKES).
Comply By: 9/16/2026 Originally Issued On: 9/16/2026

Food & Beverage General Comment

DISCUSSED MENU, HIGH RISK FOOD ITEMS, EMPLOYEE ILLNESS RECORDING, NO ONSITE COOLING, BARE HAND CONTACT, DISHWASHING, WIPING CLOTHS, AND ORDER.

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

I acknowledge receipt of the St Cloud District Office inspection report number F1037261280 from 9/16/2026

JESSICA

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Lange Board and Room LLC
Clear Lake
County/Group: Sherburne County

Inspection Info

Report Number: F1037261280
Inspection Type: Full
Date: 9/16/2026
Time: 10:51:57 AM

Food Temperature: Product/Item/Unit: MINI HOT DOG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: BASEMENT
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

Lange Board and Room LLC
Clear Lake
County/Group: Sherburne County

Inspection Info

Report Number: F1037261280
Inspection Type: Full
Date: 9/16/2026
Time: 10:51:57 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1037261280

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 9/16/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:51:57 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Lange Board and Room LLC	13892 37th St	Clear Lake, MN	55319	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 33606		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable — **COS**=corrected on-site during inspection **R**=repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature) Michele L Thomas

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33606016-0	**Date:** September 16, 2026
Facility Name: LANGE BOARD AND ROOM INC	
Facility Address: 13892 37th St Clear Lake MN 55319	

☒ **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. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

   Comments: A number of plastic containers were used as ash trays.

3. Lighted matches, cigarettes, cigars or other burning object 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: Burnt cigarette butts were observed in the exterior wood mulch landscaping.

4. Electrical wiring, devices, appliances and other equipment that is modified or damaged and constitutes an electrical shock or fire hazard shall not be used. [Minn. Stat. 144G.45 subd. 2; MSFC 604.1]

   Comments: Exposed wiring was observed in the furnace room outside of resident rooms 30 & 31.

5. Gas fired commercial cooking appliances installed on casters and appliances that are moved for cleaning and sanitation purposes shall be connected to the piping system with a connector complying with ANSI Z21.69. Movement of appliances on casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 607.4]

   Comments: No restraining device was observed on the movable kitchen gas powered appliances.

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments: Smoke alarms were missing in resident room 7 & 8.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **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: The resident smoke area known as the "Garage" had broken windows and missing siding.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee stated no resident policy was in place at this time.

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

   Comments: The licensee stated the training was done in conjunction with fire drill but the training documentation was not provided.

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 licensee stated the training was done in conjunction with fire drill but the training documentation was not provided.