Electronically Delivered

September 8, 2026

Licensee
Harmony Place
455 Main Avenue North
Harmony, MN 55939

RE: Project Number(s) SL21518017-0

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environmen - $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.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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: SL21518017-0 On August 3, 2026, through August 7, 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 35 resident(s); 35 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on August 4, 2026, at a level 3/Widespread (l). The licensee took action on August 4, 2026; however, the scope and level remain at l.	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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of three residents (R4, R11). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 430		

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0 430	Continued From page 2 R4 R4 began receiving services from the licensee on May 15, 2025, with diagnoses including type 2 diabetes. R4's Service Plan dated January 2, 2026, included the services of medication management/administration, blood sugar monitoring, and hearing aid reminders. R11 R11 began receiving services on March 24, 2026, with diagnoses including history of stroke with right side paralysis, congestive heart failure, chronic kidney disease, type 2 diabetes, and obstructive uropathy (blockage of the bladder) with presence of urinary catheter. R11's Service Plan dated March 24, 2026, included medication management/administration, assistance of one staff for transfers, blood sugar monitoring, and catheter management. R4 and R11's records lacked evidence that the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract On August 5, 2026, at 3:39 p.m., licensed assisted living director (LALD)-A stated she was	0 430		

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0 430	Continued From page 3 creating a signature page for residents to sign at their time of admission to include their receipt of the UDALSA. She further stated documentation about receiving the UDALSA was inconsistent with resident records across the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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	0 480		

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0 480	Continued From page 4 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 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	0 480		

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0 480	Continued From page 5 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 August 3, 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		
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	0 550		

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0 550	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to post the required contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 3, 2026, at 12:45 p.m. during a facility review of postings, the surveyor noted various postings in the facility foyer. The postings lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On August 3, 2026, at 3:35 p.m., licensed assisted living director (LALD)-A stated she was not aware of the Office of Ombudsman for Mental Health and Developmental Disabilities posting requirement; but would find that information and post it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 640	Continued From page 7	0 640		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 3, 2026, at 12:45 p.m. during a facility tour, the surveyor noted no 911 emergency number posted in the facility common areas or by	0 640		

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0 640	Continued From page 8 facility supplied telephones as required. On August 3, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated the licensee had this posting hung in various locations in the facility previously; however, had not noticed they were no longer posted as required. 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	0 650		

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0 650	Continued From page 9 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 records contained the required content for one of two employees (unlicensed personnel (ULP)-H). 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-H started employment on June 16, 2026, to provide direct care services to the licensee's residents. On August 4, 2026, at 8:15 a.m., the surveyor observed ULP-H set up and administer R9's oral medications. ULP-H stated she received training from the licensee's licensed practical nurse (LPN) and registered nurse (RN). ULP-H's employee record lacked evidence of her core training and competencies from her time of hire. On August 7, 2026, at 12:00 p.m., licensed practical nurse (LPN)-C stated all training competencies had been completed for ULP-H; however, she was behind on filing paperwork and was unable to locate the paper documents.	0 650		

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0 650	Continued From page 10 The licensee's Training Unlicensed Personnel for Medication, Treatment, and Therapy Administration policy dated June 2026, indicated the RN will document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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).	0 775		

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0 775	Continued From page 11 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 12 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 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 August 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		

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01290	Continued From page 13	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 interview and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NET Study 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS) with the assisted living license for one of 29 employees (unlicensed personnel (ULP-I). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on August 4, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems	01290		

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01290	Continued From page 14 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 August 3, 2026, at 3:06 p.m., the surveyor received the licensee's NETStudy 2.0 roster for health facility identification (HFID)-21518, as printed on August 3, 2026. On August 3, 2026, at 3:50 p.m., the surveyor received the licensee's current employee list. On August 4, 2026, at 11:05 a.m., the surveyor reviewed both documents and noted ULP-I was found on the facility's employee roster; however, was not found on the facility's NETStudy roster. ULP-I had a rehire date of November 18, 2024, to provide direct care services to the licensee's residents. NETStudy 2.0 dated August 4, 2026, indicated ULP-I lacked a current/eligible background study. The licensee failed to ensure ULP-I had a current/eligible background study. On August 4, 2026, at 11:55 a.m., licensed assisted living director (LALD)-A stated a new management company took over in October 2026, managed the background studies for the licensee; however, a review of the employee roster and NETStudy roster should have been completed to ensure all employees were cleared. LALD-A further stated ULP-I was a current employee and had worked independently without direct supervision.	01290		

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01290	Continued From page 15 The licensee's Background Checks policy dated June 2024, indicated [licensee name] will conduct background checks on applicants and other individuals as required by federal, state, and local law. Human Resources will make all reasonable efforts to ensure that background checks are complete prior to the first day of team member orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on August 4, 2026; however, the scope and level remain at I.	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01420		

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01420	Continued From page 16 review, licensee failed to provide clear instructions by a registered nurse (RN) to unlicensed personnel (ULP) for delegated foley catheter bag emptying/exchange for one of one resident (R11). 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: R11 began receiving services on March 24, 2026, with diagnoses including history of stroke with right side paralysis, congestive heart failure, chronic kidney disease, type 2 diabetes, and obstructive uropathy (blockage of the bladder) with presence of urinary catheter. R11's Service Plan dated March 24, 2026, included medication management/administration, assistance of one staff for transfers, blood sugar monitoring, and catheter management. On August 4, 2026, at 1:50 p.m., the surveyor observed unlicensed personnel (ULP)-D empty R11's urinary catheter bag. ULP-D stated she had administered medications earlier in the morning, checked his blood sugar and assisted with insulin administration. ULP-D returned to the computer to document the task of managing the catheter bag and stated she did not note any further written instructions for what the ULP should watch for and report to nursing.	01420		

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01420	Continued From page 17 R11's task record dated August 2026, listed the task "Catheter: requires assistance". No other instructions were written. The licensee failed to provide clear written instructions by the RN to the ULP for what to report to the nurse regarding R11's urinary catheter output (blood, low output, and cloudy or foul smelling urine). On August 7, 2026, at 12:45 p.m., clinical nurse supervisor (CNS)-B stated a home care agency placed the indwelling urinary catheter and staff were tasked to empty the urinary catheter bag and she was working on a custom task to include written instructions for any resident with a catheter. The licensee's Delegation of Nursing Tasks policy dated June 2026, indicated an RN may delegate nursing services to unlicensed staff after including written instruction for performing the procedure of the resident in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01620 SS=F	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	01620		

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01620	Continued From page 18 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; (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	01620		

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01620	Continued From page 19 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment 14 days after admission for one of five residents (R7) and further failed to complete a reassessment not to exceed 90 days for four of five residents (R4, R5, R6, R11). 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: 14 DAY ASSESSMENT R7 R7 began receiving services from the licensee on June 2, 2026, with diagnoses including unspecified dementia. R7's Service Plan dated June 2, 2026, included medication management/administration, blood sugar monitoring, stand by assistance with grooming, dressing, and showers. On August 4, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications, complete a blood sugar	01620		

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01620	Continued From page 20 check via finger poke, administer insulin and served R7 breakfast. On August 5, 2026, at 9:00 a.m., R7's MN Senior Living-Level of Care and Service Plan V.3 (used as the RN comprehensive assessments) were reviewed. The licensee completed an RN comprehensive assessment on the day of admission (June 2, 2026); however, failed to complete a 14-day reassessment (due June 16, 2026) as required. No reassessments have been completed since R7's admission date. ONGOING 90 DAY ASSESSMENTS R4 R4 began receiving services from the licensee on May 15, 2025, with diagnoses including type 2 diabetes. R4's Service Plan dated January 2, 2026, included the services of medication management/administration, blood sugar monitoring, and hearing aid reminders. On August 4, 2026, at 8:30 a.m., the surveyor observed ULP-D set up and administer medications, check R4's blood sugar via his Libre blood sugar sensor/monitor and set up and observed R4 self-administer his two insulin pens. On August 5, 2026, at 10:00 a.m., the surveyor reviewed the last three RN comprehensive assessments. R4's record included the following reassessments: -October 11, 2025; -January 2, 2026; and -April 2, 2026 The licensee failed to ensure the RN completed a reassessment not to exceed 90 days following the RN assessment completed on April 2, 2026	01620		

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01620	Continued From page 21 (due July 1, 2026). R5 R5 began receiving services from the licensee on May 13, 2025, with diagnoses including type two diabetes, history of stroke with right sided paralysis, and disruptive dysregulation disorder. R5's Service Plan dated January 30, 2026, indicated he received the service including medication management/administration, blood sugar monitoring, assistance with toileting, bathing, and transfers/ambulation, stand-by assistance for dressing, and safety checks. On August 3, 2026, at 2:24 p.m., the surveyor observed ULP-G prepare R5's afternoon medications. ULP-G administered R5's eye drops, donned clean gloves and squirted an undetermined amount of diclofenac 1% gel to her gloved fingers and applied to R5's knees. On August 6, 2026, at 11:00 p.m., the surveyor reviewed R5's record and noted most recent reassessments dated January 5, 2026, and April 9, 2026. No reassessments were found after April 9, 2026. The licensee failed to ensure the RN completed a reassessment not to exceed 90 days (due July 8, 2026). R6 R6 began receiving services from the licensee on December 2, 2024, with diagnoses including epilepsy and mild cognitive impairment. R6's Service Plan dated February 25, 2026, indicated he received services including medication management/administration.	01620		

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01620	Continued From page 22 On August 3, 2026, at 3:10 p.m., the surveyor observed ULP-G prepare R6's diclofenac 1% gel for administration. ULP-G obtained the diclofenac gel from the medication cart, reviewed the instructions on the medication administration record (MAR) and grabbed a clean set of gloves. ULP-G then entered R6's apartment, donned the gloves and squirted an undetermined amount of diclofenac 1% gel to her gloved fingers. She then applied the gel to R6's shoulders and the tops of both hands. On August 6, 2026, at 12:00 p.m., the surveyor reviewed R6's record for the following reassessments: -October 15, 2025; -February 25, 2026; and -August 3, 2026 (during survey) There were 159 days between the assessments completed on October 15, 2025, and February 25, 2026 (exceeding 90 days). Furthermore, there were 133 days between February 25, 2026, and August 3, 2026 (exceeding 90 days). R11 R11 began receiving services on March 24, 2026, with diagnoses including history of stroke with right side paralysis, congestive heart failure, chronic kidney disease, type 2 diabetes, and obstructive uropathy (blockage of the bladder) with presence of urinary catheter. R11's Service Plan dated March 24, 2026, included medication management/administration, assistance of one staff for transfers, blood sugar monitoring, and catheter management. On August 4, 2026, at 1:50 p.m., the surveyor observed ULP-D empty R11's urinary catheter	01620		

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01620	Continued From page 23 bag. ULP-D stated she had administered medications earlier in the morning, checked his blood sugar and assisted with insulin administration. R11's record included the following RN assessments/reassessments: -March 24, 2026; -April 6, 2026; and -July 23, 2026 (17 days late) The licensee failed to ensure the RN completed a reassessment not to exceed 90 days (due July 5, 2026). On August 7, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated she knew she was behind on RN assessments for all residents and was working on it. The licensee's Resident's Initial and Ongoing Assessments policy dated June 2026, indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90 days d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 24 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of eleven residents (R7). 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: R7 began receiving services from the licensee on June 2, 2026, with diagnoses including unspecified dementia. R7's Service Plan dated June 2, 2026, included medication management/administration, blood	01760		

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01760	Continued From page 25 sugar monitoring, stand by assistance with grooming, dressing, and showers. R7's medication administration record (MAR) dated August 2026, indicated furosemide (medication for water retention) 20 milligrams (mg), give 0.5 tablet (10 mg) by mouth every other day, hold if blood pressure is less than 100/60. On August 4, 2026, at 11:15 a.m., the surveyor observed unlicensed personnel (ULP)-H set up and administer two oral medications (furosemide and prednisone-an oral steroid). ULP-H also prepared R7's midday insulin pen. ULP-H went to R7's room and completed a finger poke to check R7's blood sugar (resulting in 242), and injected R7's insulin. ULP-H returned to the computer to document the blood sugar reading and her administration of medications on R7's electronic medical record (EMR). ULP-H noted she needed to complete a blood pressure check and returned to R7's room and completed a blood pressure via wrist cuff on R7's right wrist and noted a blood pressure reading of 88/40. Upon returning to the EMR, the surveyor asked ULP-H if there were written parameters for R7's blood pressure. ULP-H stated she was not aware of anything but would look. Upon a closer look, ULP-H stated the blood pressure was to be completed prior to giving the noon furosemide and included instructions to hold the furosemide for any blood pressure lower than 100/60. ULP-H stated she had not noted that direction before this and had always checked the blood pressure after administering midday medications. ULP-H contacted licensed practical nurse (LPN)-C . LPN-C came to the memory care unit and reviewed the medication pass and the blood pressure steps with ULP-H and stated R7 should	01760		

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01760	Continued From page 26 not have received the furosemide with the blood pressure reading obtained which then resulted in a medication error. LPN-C reviewed the written instructions on the EMR with ULP-H and contacted clinical nurse supervisor (CNS)-B. On August 4, 2026, at 11:40 a.m. CNS-B stated she followed up with the medication error and rechecked R7's blood pressure with a different blood pressure unit and stated with that, R7's blood pressure was within the acceptable parameters to have the furosemide. CNS-B stated moving forward the wrist blood pressure cuff would not be used as it likely was not accurate. CNS-B stated the proper steps were that ULP-H should have checked R7's blood pressure prior to administering the furosemide. The licensee failed to ensure medications were administered as ordered. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated June 2026, indicated the ULP would complete procedures for checking the resident's medication administration record and medication profile, treatment and therapy profile and any additional information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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01890	Continued From page 27 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 label a time sensitive medication with an opened date for two of 11 residents (R7, R4) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R7 R7 began receiving services from the licensee on June 2, 2026, with diagnoses including unspecified dementia. R7's Service Plan dated June 2, 2026, included medication management/administration. On August 4, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications, complete a blood sugar check via finger poke, administer insulin and served R7 breakfast. The surveyor observed R7's Novolog insulin to lack an open date. ULP-H stated she was not the one to open it and confirmed there was no indication when the pen	01890		

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01890	Continued From page 28 had been opened for use. R7's provider's orders dated July 1, 2026, indicated Novolog 100 milligrams/milliliter (mg/ml), inject 8 units under the skin with each meal. R4 R4 began receiving services from the licensee on May 15, 2025, with diagnoses including type 2 diabetes. R4's Service Plan dated January 2, 2026, included the services of medication management/administration. On August 4, 2026, at 8:30 a.m., the surveyor observed ULP-D set up and administer medications, check R4's blood sugar via his Libre blood sugar sensor/monitor and set up and observed R4 self-administer his two insulin pens. The surveyor observed R4's glargine insulin pen included an open date of July 26, 2026; however, R4's Novolog insulin pen lacked an open date. ULP-D confirmed the Novolog insulin pen did not indicate when it had been opened for use. R4's provider's orders dated April 2, 2026, indicated Novolog 100 mg/ml inject 5 units under the skin with each meal. On August 5, 2026, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to indicate the date when any insulin pen was removed from the refrigerator and first opened. Novolog manufacturer's instructions dated February 2015, indicated the NovoLog FlexTouch Pen should be thrown away after 28 days, even if it still has insulin left in it.	01890		

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01890	Continued From page 29 The licensee's Medications Labeling and Storage policy dated June 2026, indicated the label included the resident's name, dose, frequency, route instructions for use, and expiration date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 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,	01950		

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01950	Continued From page 30 specific instructions and documented those instructions in the resident record for one of three residents (R7) with treatments. 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: On August 4, 2026, at 11:15 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided treatments including management of blood sugar monitoring. R7 began receiving services from the licensee on June 2, 2026, with diagnoses including unspecified dementia. R7's signed prescriber's orders dated June 2, 2026, included an order for blood sugar monitoring three times daily with insulin dosing. R7's Service Plan dated June 2, 2026, included medication management/administration and blood sugar monitoring. On August 4, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications, complete a blood sugar check via finger poke, and administer Novolog insulin. ULP-H documented the blood sugar reading on R7's electronic medication administration record (eMAR). The blood sugar	01950		

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01950	Continued From page 31 documentation was included in the same area as her Novolog insulin administration documentation. ULP-H confirmed there were no written blood sugar parameters to guide ULP when to notify nursing. On August 6, 2026, at 9:00 a.m. during record review, the surveyor noted the licensee had started a new task of blood sugar monitoring on the evening of August 4, 2026, (during survey) separate from the Novolog insulin that did include blood sugar parameters to indicate when to notify nursing. R7's record lacked written instructions for R7's blood sugar parameters and when to notify nursing. On August 7, 2026, at 12:30 p.m., CNS-B stated she was aware of the need for blood sugar parameters being written for the ULP to reference for each resident with blood sugar monitoring; however, she missed adding this to R7's blood sugar task/instructions and had added it on August 4, 2026, during the time of survey and after the surveyor inquired about it with the ULP. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated June 2026, indicated the RN may delegate administration of medications, treatment and therapy if the ULP have satisfied training requirements if the RN has developed written , specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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02040	Continued From page 32	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a 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	02040		

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02040	Continued From page 33 Environment Inspection Report (PEIR) dated August 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;	02110		

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02110	Continued From page 34 (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in assisted living facilities with dementia care were created and provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R4, R7, R11). 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: The licensee was licensed as an Assisted Living with Dementia Care facility on April 28, 2026. R4, R7, and R11's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care	02110		

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02110	Continued From page 35 and how the philosophy should be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On August 5, 2026, at 3:39 p.m., licensed assisted living director (LALD)-A stated she was not aware of the dementia care policies and could not locate them in the set of policies available to her on the corporate SharePoint site (the location for all facility policies); and further confirmed the list of dementia care policies had not been provided to each resident and/or representative as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02240	Continued From page 36	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not	02240		

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02240	Continued From page 37 retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's complaint procedure was provided and a written acknowledgement was received for two of three residents (R4, R11). 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: R4 R4 began receiving services from the licensee on May 15, 2025, with diagnoses including type 2 diabetes. R4's Service Plan dated January 2, 2026, included the services of medication management/administration, blood sugar monitoring, and hearing aid reminders. R11 R11 began receiving services on March 24, 2026, with diagnoses including history of stroke with	02240		

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02240	Continued From page 38 right side paralysis, congestive heart failure, chronic kidney disease, type 2 diabetes, and obstructive uropathy (blockage of the bladder) with presence of urinary catheter. R11's Service Plan dated March 24, 2026, included medication management/administration, assistance of one staff for transfers, blood sugar monitoring, and catheter management. R4 and R11's records lacked written acknowledgement they or their resident representative had received the licensee's complaint procedure. On August 5, 2026, at 3:30 p.m., licensed assisted living director (LALD)-A stated the licensee's complaint notice was found in the resident handbook and was provided to each resident at the time of admission; however, she did not have the practice of obtaining written acknowledgement residents had received this and was creating a document to be used consistently for residents to sign at the time of move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the	02320		

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HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

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02320	Continued From page 39 services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow delegated procedures for medication administration for two of eleven residents (R5, R6) as required. 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: R5 R5 began receiving services under the licensee's assisted living with dementia care license on May 13, 2025, with diagnoses including type two diabetes, history of stroke with right sided paralysis, and disruptive dysregulation disorder. R5's Service Plan dated January 30, 2026, indicated he received medication management/administration. On August 3, 2026, at 2:24 p.m., the surveyor observed unlicensed personnel (ULP)-G prepare R5's afternoon medications. ULP-G administered R5's eye drops, donned clean gloves and squirted an undetermined amount of diclofenac 1% gel to her gloved fingers and applied it to R5's knees. ULP-G stated she had been trained for	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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
02320	Continued From page 40 medication administration by the licensee's nurse. R5's Medication Administration Record (MAR) dated August 2026, included two medications for blood thinning, one for high blood pressure, one for heart rate regulation, one for seizures, one supplement, one oral medication for mild pain, one for diarrhea, one eye drop for allergies, and one topical medication for pain. R5's signed prescriber's orders dated March 28, 2026, included diclofenac 1% gel, apply 4 grams (gm) four times daily to both knees for knee pain R6 R6 began receiving services under the licensee's assisted living with dementia care license on December 2, 2024, with diagnoses including epilepsy and mild cognitive impairment. R6's Service Plan dated February 25, 2026, indicated he received services including medication management/administration. On August 3, 2026, at 3:10 p.m., the surveyor observed ULP-G prepare R6's diclofenac 1% gel for administration. ULP-G obtained the diclofenac gel from the medication cart, reviewed the instructions on the MAR and grabbed a clean set of gloves. ULP-G then entered R6's apartment, donned the gloves and squirted an undetermined amount of diclofenac 1% gel to her gloved fingers. She then applied the gel to R6's shoulders and the tops of both hands. R6's MAR dated August 2026, included one medication for blood thinning, one for cholesterol, one for high blood pressure, one for gas relief, one for sleep, one for seizures, one for mild pain, one for constipation, one for cough, one for	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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
02320	Continued From page 41 allergies, two supplements, and one topical pain medication. R6's signed prescriber's orders dated December 15, 2025, indicated diclofenac 1% gel, apply 2 gm to shoulders and painful joints of both hands three times daily. The licensee failed to use the appropriate measuring tool to administer the correct dosage of diclofenac gel. On August 3, 2026, at 3:50 p.m., clinical nurse supervisor (CNS)-B stated the ULP have been trained to use the measuring tool for accurate dosing of the diclofenac gel. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated June 2026, indicated medications, treatment and therapy always need to be administered according to the six rights: a. Person b. Dosage c. Route d. Time e. Medication f. Charting/documentation No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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 42 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 and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Upon entrance to the facility on August 3, 2026, at 11:00 a.m. the surveyor observed the front entrance and entryway of the facility. No electronic monitoring signage was observed. On August 3, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated the required electronic monitor signage was usually posted at the front door/foyer area, confirmed it was now missing and that she likely had removed it. No further information was provided.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(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 43 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

Harmony Place
455 MAIN AVENUE NORTH
Harmony, MN 55939
Fillmore County
Parcel:

Phone: 5075000383
dbaumann-fern@arborgardenplace.com

License Info

License: HFID 25158
Darci Baumann-Fern
Risk:
License:
Expires on:
CFPM: Darci Baumann-Fern
CFPM #: FM28973; Exp: 9/21/2029

Inspection Info

Report Number: F1045261116
Inspection Type: Full - Single
Date: 8/3/2026 Time: 1:28:21 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.15A *Priority Level: Priority 3 CFP#: 42*
MN Rule 4626.0255A Thoroughly wash all raw fruits and vegetables before, cutting, combining with other ingredients, cooking, serving, or offering for human consumption in ready-to-eat form. They must be washed in potable water or by using approved chemicals specifled in part 4626.1625.
COMMENT:
It was thought the heads of lettuce were "prewashed". Labeling on the package stated "wash before use". Lettuce to be rinsed before prep/use using the produce sink.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.13 *Priority Level: Priority 2 CFP#: 51*
MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.
COMMENT:
Water filter located behind the coffee dispensing equipment was last replaced in 2025. Replace annually...
Comply By: 8/17/2026 Originally Issued On: 8/3/2026

Food & Beverage General Comment

This was a routine inspection conducted on an assisted living facility with a full kitchen. Foods prepared from scratch with cooking, cooling and reheating practices.

Observations/Topics Discussed
*Ill Employee Policy
*Personal Hygiene and handwashing practices
*No barehand contact with ready to eat foods
*Sanitization practices
*Pest Management
*Food storage practices
*Cooling practices

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

I acknowledge receipt of the Rochester District Office inspection report number F1045261116 from 8/3/2026

Darci Baumann-Fern
Senior Executive Director

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

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

Harmony Place
Harmony
County/Group: Fillmore County

Inspection Info

Report Number: F1045261116
Inspection Type: Full
Date: 8/3/2026
Time: 1:28:21 PM

Food Temperature: Product/Item/Unit: Coleslaw**; Temperature Process:** Cold-Holding
Location: 2 dr Upright at 39F Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Whirlpool at 41.9 Degrees F.
Comment: Internal temp - firm adjusted unit and will log cooler daily to ensure adequate temp
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

Harmony Place
Harmony
County/Group: Fillmore County

Inspection Info

Report Number: F1045261116
Inspection Type: Full
Date: 8/3/2026
Time: 1:28:21 PM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

New Record: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To**
Comment: 100 ppm
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL21518017	**Date:** 8/5/2026
Facility Name: Harmony Place	
Facility Address: 455 Main Ave N., Harmony, MN 55939	

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

   Comments: The fire doors from the maintenance office leading out into the resident corridor and the fire doors on the food panty room did not close and latch on their own. Fire-rated doors should be maintained self-closing and should properly close and latch.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: Several residents were seated in chairs that were partially obstructing the front entryway. Furniture should be removed from the path of egress and the egress path from the front doors should be maintained clear of obstruction.

4. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff

shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: A remote release button was installed in an electrical closet near the boiler room. The button was outside of the locked area and was not readily accessible during an emergency. The surveyor inquired with facility staff about their knowledge and understanding of the operation of the remote release button during an emergency and staff indicated they were unaware of the existence or location of the button. There were no references to the remote release button in facility emergency evacuation plans, and staff were not trained on the use or even existence of the button. The button is not in an approved location. The remote release mechanism for the controlled egress doors should be located in an accessible, approved location, and staff should be trained in the proper use of the release.

5. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments: The egress door leading out of the dining room area had two different door handles installed to operate the door. Egress through this door would require special knowledge and effort to operate in an emergency. One of the door handles should be removed, and door operation should not require two separate operations at once to egress from the facility.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. The FSEP contained several different and contradictory plans for staff actions during evacuation. Facility staff could not provide accurate and up to date staff action documentation to the surveyor. The FSEP should include site-specific staff actions for evacuation.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide unique resident needs for evacuation. No procedures were provided to the surveyor that included procedures for resident evacuation that identified unique resident needs. No information was located in the FSEP including this information during survey and no further documentation was provided.

3. 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 failed to provide record of employee training on fire safety and evacuation policies. No record of employee trainings on the FSEP was provided to the surveyor. Staff should receive training on hire and at least twice a year thereafter.

4. 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 failed to provide record of resident training on fire safety and evacuation policies. No record of resident trainings on the FSEP was provided to the surveyor. Trainings should be provided for residents at least once per year.

5. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide adequate documentation of fire drills. Records of several drills were provided but were not sufficient to satisfy requirements. Fire drills should occur at least twice per shift per year and at least once every other month.

☒ **TAG IDENTIFICATION: 2040**

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

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

Comments: The licensee failed to provide adequate documentation of a safety risk assessment and mitigations for identified risks. Documentation of a safety risk assessment was provided but was not accurate or complete and failed to outline any mitigation efforts for the identified risks. The safety risk assessment was not specific or relevant to the facility and facility staff indicated that the information provided was general information from a third party and did not account for any specific assessment of the specific risks to the facility. The safety risk assessment should be accurate and should be reviewed to include mitigations to identified hazards.