Electronically Delivered

October 23, 2026

Licensee
Harding Place
24448 296th Avenue
Pierz, MN 56364

RE: Project Number(s) SL34822016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 16, 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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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: SL34822016-0 On September 14, 2026, through September 16, 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 20 residents; 20 receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 15, 2026, issued for SL34822016-0, tag identification 1290. The licensee took action on September 15, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 14, 2026, for the specific Minnesota Food Code violations. The	0 480		

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0 480	Continued From page 3 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		
0 510 SS=E	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 ensure services were provided according to accepted health care, medical, or nursing standards regarding infection control for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 510		

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0 510	Continued From page 4 found to be pervasive). The findings include: During the entrance conference on September 14, 2026, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided catheter care services to residents at the facility. On September 15, 2026, at 10:04 a.m., the surveyor observed unlicensed personnel (ULP)-C perform hand hygiene, put on gloves, obtain R5's urinal that was sitting on a paper towel on the sink in the shared bathroom in R5's pod (a block of rooms in a shared hallway), empty R5's catheter into the urinal, measure the amount of urine, return to the shared bathroom in R5's pod, empty the urinal into the toilet, fill the urinal with water from the sink, dump the water into the toilet, and place the empty urinal on a paper towel on the bathroom sink. ULP-C then removed gloves, washed hands at the bathroom sink in the shared bathroom and returned to the medication cart to document R5's output. The surveyor did not observe ULP-C disinfect the urinal prior to storing it on the shared bathroom sink. On September 15, 2026, at 1:28 p.m., ULP-C stated ULP-C received infection control training annually. Furthermore, ULP-C stated rinsing urinals with vinegar was a task for evening shift and the other residents in the same pod usually used other bathrooms at the facility. On September 16, 2026, at 11:48 a.m., CNS-B stated infection control training was provided to staff upon hire and annually. CNS-B further stated urinals were disinfected nightly with vinegar and were to be stored in the resident's room. Additionally, assisted living director in	0 510		

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0 510	Continued From page 5 residency (ALDIR)-A stated the bathroom in R5's pod is a shared bathroom. The licensee's Required Annual Training policy dated June 23, 2025, indicated training on disinfecting reusable equipment and disinfecting environmental surfaces was provided to all staff who performed direct care services every twelve months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 6 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 730		

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0 730	Continued From page 7 situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 10:12 a.m., assisted living director in residency (ALDIR)-A stated the licensee was familiar with the current minimum assisted living requirements. R2's diagnoses included retinitis pigmentosa of both eyes (vision loss), diabetes, depression, anxiety with adjustment disorder, and bipolar 1 disorder (extreme shifts in mood, energy, and activity levels). R2's Service Plan (Waiver) - Addendum to Contract dated May 26, 2026, indicated R2's services included assistance with activities, bathing, blood glucose monitor, dietary needs, dressing, grooming, manage behavior - agitation, manage behavior - other mental health need, med (medication) administration, med (medication) setup, and safety checks. On September 15, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled morning medications. R2's Service Recap Summary dated August 2026, indicated the following: -August 3, 7, 9, 12, 13, 17, 23, 26, and 27, respectively, indicated R2 did not have dietary needs or percentage of meal eaten documented at PM (evening); -August 27 indicated R2 did not have dietary needs, manage behavior - agitation, or percentage of meal eaten documented at 6:00 a.m.; -August 27 indicated R2 did not have percentage	0 730		

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0 730	Continued From page 8 of meal eaten documented at Midday; and -August 31 indicated R2 did not have percentage of meal eaten documented at Midday. R2's Service Recap Summary dated September 2026, indicated the following: -September 1, 2, 3, and 4, respectively, indicated R2 did not have percentage of meal eaten documented at Midday; -September 3, 4, and 15, respectively, indicated R2 did not have dietary needs or percentage of meal eaten documented at 6:00 a.m.; -September 3, 4, 5, 6, 9, and 14, respectively, indicated R2 did not have dietary needs or percentage of meal eaten documented at PM (evening); and -September 10 indicated R2 did not have activities, ambulation, dressing, general, grooming, or manage behavior - agitation documented at 6:00 a.m. R2's record lacked documentation of the services noted above, or the reason why the services were not administered to R2. On September 15, 2026, at 11:43 a.m., clinical nurse supervisor (CNS)-B stated R2 received all the services noted above, however, staff did not document the services in R2's Service Recap Summary record. CNS-B further stated ULPs were expected to document services on the Service Recap Summary right after the service was provided. The licensee's Resident Records - Information & Content policy dated August 1, 2021, indicated documentation that services have been provided as identified in the service plan must be included in the resident record.	0 730		

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0 730	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2)	0 775		

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0 775	Continued From page 10 days	0 775		
0 780 SS=D	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, record review, and interview, the licensee failed to ensure the physical environment of the facility was	0 780		

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0 780	Continued From page 11 maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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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
0 800	Continued From page 12 by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 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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0 810	Continued From page 13 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 810		

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0 810	Continued From page 14 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 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents at the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 970		

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0 970	Continued From page 15 and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 14, 2026, at 10:11 a.m., assisted living director in residency (ALDIR)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated Assisted Living Contract: Terms and Conditions, Section 15. Resident Handbook: By signing this Agreement (assisted living contract), Resident agrees to abide by Provider's policies, rules and regulations, which are described in the Resident Handbook and which are incorporated by reference into this Agreement (assisted living contract) [sic]. The licensee's Resident Handbook dated December 1, 2021, section Personal Property indicated (licensee name) is not responsible for damages or repair of any personal property. On September 16, 2026, at 12:12 p.m., ALDIR-A stated what the resident handbook provided was the most current and provided to all residents. ALDIR-A further stated ALDIR-A was not aware the resident handbook had implied the licensee was not responsible for any damage or repair of resident's personal property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01290	Continued From page 16	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 current employee records contained all the required content to include a current background study clearance letter for two of eight employees (unlicensed personnel (ULP)-G, ULP-H). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01290		

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01290	Continued From page 17 The findings include: This resulted in an immediate correction order on September 15, 2026. During the entrance conference on September 14, 2026, at 10:29 a.m., assisted living director in residency (ALDIR)-A stated the licensee was aware of required contents in an employee record. ULP-G ULP-G was hired on July 20, 2025, to provide direct care to residents at the facility. The licensee's Schedule dated September 13, 2026 - September 19, 2026, indicated ULP-G was scheduled to work one shift. R3's Med (medication) Admin (administration) Summary- Month dated September 2026, indicated ULP-G administered R3's medications on September 2, 7, 11, 12, and 13, respectively. ULP-G's employee record lacked a current, cleared background study through the MN DHS NETStudy 2.0 website. ULP-H ULP-H was hired on November 13, 2025, to provide direct care to residents at the facility. The licensee's Schedule dated September 13, 2026 - September 19, 2026, indicated ULP-H was scheduled to work seven shifts. R's Service Recap Summary- Month dated September 2026, indicated ULP-H documented R3's dietary needs at 6:00 a.m.	01290		

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01290	Continued From page 18 ULP-H's employee record lacked a current, cleared background study through the Minnesota Department of Human Services (MN DHS) NETStudy 2.0 website. On September 14, 2026, from 2:55 p.m. to 3:07 p.m., the surveyor reviewed the licensee's NETStudy 2.0 Roster with ALDIR-A. ALDIR-A stated ALDIR-A was responsible for completing background studies upon hire, prior to any direct resident cares. Additionally, ALDIR-A stated ULP-G and ULP-H worked unsupervised. ALDIR-A provided the surveyor previous cleared background studies for ULP-G and ULP-H dated July 23, 2025, and October 22, 2025, respectively. ALDIR-A completed a search on the NETStudy 2.0 website for ULP-G and ULP-H. The results indicated ULP-G and ULP-H were no longer affiliated with the licensee. ALDIR-A stated ALDIR-A would probably not know if ULP-G and ULP-H would become ineligible. On September 15, 2026, at 8:37 a.m., ALDIR-A stated the licensee's management company did not have a current, cleared background study for ULP-G or ULP-H. ALDIR-A further stated the licensee completed an audit on the NETStudy 2.0 Roster last month and both employees were listed. However, ALDIR-A was not sure why ULP-H and ULP-G were not on the current NETStudy 2.0 Roster. The licensee's Background Checks policy dated August 1, 2022, indicated background studies would be conducted on all team members. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision -	01290		

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01290	Continued From page 19 An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start	01550		

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01550	Continued From page 20 date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (director of maintenance (DM)-D) received the required amount dementia training upon hire. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 14, 2026, at 10:29 a.m., assisted living director in residency (ALDIR)-A stated the licensee was aware of required contents in an employee record. DM-D was hired on April 28, 2025, to provide maintenance around the assisted living facility. On September 15, 2026, at approximately 10:00 a.m., the surveyor observed DM-D on a facility tour with the Minnesota Department of Health	01550		

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01550	Continued From page 21 engineer surveyor. DM-D's online transcript indicated DM-D had completed a total of three hours of dementia training on April 30, 2025. On September 15, 2026, at 12:09 p.m., clinical nurse supervisor (CNS)-B stated all non-direct care staff were assigned three hours of dementia training upon hire. Additionally, ALDIR-A and CNS-B stated they were unaware that non-direct care staff were required to complete four hours of dementia training upon hire. The licensee's 10.03 Orientation and Training of Ancillary (Non-Direct Care) Personnel policy dated August 23, 2025, stated all personnel who do not provide direct care, to include maintenance, must complete at least four hours of dementia-related training within 160 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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	01760		

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01760	Continued From page 22 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 documentation of the administration of medications included all required content for one of two residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 10:17 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided medication management to residents at the facility. R6's diagnoses included diabetes. R6's Service Plan (Waiver)- Addendum to Contract dated June 16, 2026, indicated R6's services included medication administration eight times per day and blood glucose checks four times per day.	01760		

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01760	Continued From page 23 R6's prescriber orders dated June 23, 2026, included orders for Novolog Flexpen insulin 100 units/milliliter (mL)- nine (9) units to be administered daily at 7:30 a.m., except work days on Mondays, Thursdays, and Fridays give six (6) units; Novolog Flexpen insulin 100 units/mL- five (5) units to be administered daily at 12:30 p.m., except work days on Mondays, Thursdays, and Fridays give four (4) units; and Novolog Flexpen insulin 100 units/mL-seven (7) units to be administered daily at 5:00 p.m. In addition to the Novolog orders, administer additional Novolog units per the below sliding scale (a scale directing the amount of insulin that should be administered based off the blood glucose result): - less than 199 or R6 is not eating the meal= administer 0 units; - 200 - 250 = administer 1 unit; - 251 - 300 = administer 2 units; - 301 - 350 = administer 3 units; - 351 - 400 = administer 4 units; and - over 401 notify MD (physician). On September 15, 2026, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-C administer a total of 13 units of Novolog insulin to R6 per the sliding scale from R6's blood glucose reading of 394. ULP-C documented on R6's electronic medication administration record (EMAR) R6 was administered nine (9) units plus an additional four (4) units (from the sliding scale) of Novolog Flexpen insulin. ULP-C stated ULP-C was trained to document how many additional Novolog insulin units were administered to R6 based on the blood glucose sliding scale results. R6's Med (medication) Admin (administration) Summary- Month dated September 2026, indicated the following: -September 2, 2026, at 7:30 a.m., lacked how	01760		

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01760	Continued From page 24 many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -September 7, 2026, at 7:30 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -September 7, 2026, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -September 10, 2026, at 7:30 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -September 11, 2026, at 7:30 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; and -September 12, 2026, at 7:30 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results. On September 16, 2026, at 12:01 p.m., clinical nurse supervisor (CNS)-B stated R6's documentation for Novolog insulin administered based on the sliding blood glucose scale was supposed to have the actual amount of insulin units documented with each entry written in the notes section on R6's EMAR. CNS-B stated ULPs were trained to document the additional amount of insulin given in the notes section, however, CNS-B stated some entries lacked the additional sliding scale insulin units administered. The licensee's 12.11 Medication Management: Administration and Setup policy dated March 20, 2026, indicated for medication reminders or administration, the documentation must include	01760		

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01760	Continued From page 25 the medication name, dosage, date and time administered, and the method and route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of two residents (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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
01770	Continued From page 26 14, 2026, at 10:17 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided medication management to residents at the facility. R10's diagnoses included hypertension (HTN-high blood pressure), low back pain, and paranoid schizophrenia. R10's Service Plan (Waiver)- Addendum to Contract dated June 16, 2026, indicated R10's services included medication set up by the licensed practical nurse (LPN) every 28 days. R10's prescriber orders dated September 3, 2025, included an order for Flexeril (muscle relaxer) 5 milligrams (mg) one tablet by mouth twice daily as needed for pain. R10's Med (medication) Admin (administration) Summary- Actual- Month dated June 2026, and July 2026, respectively, indicated R10 was administered Flexeril 5 mg four times. On September 15, 2026, at 1:20 p.m., the surveyor reviewed the medication cart with unlicensed personnel (ULP)-C and observed a bubble pack (paperboard with a foil back to organize tablets) with a handwritten label including R6's information of Flexeril 5 mg one tablet by mouth twice daily as needed for pain. ULP-C stated a nurse had setup R6's Flexeril tablets in the bubble pack. R10's record lacked documentation for the Flexeril medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup at the time	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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
01770	Continued From page 27 of setup. On September 16, 2026, at 9:55 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was trying to locate the documentation for R10's Flexeril medication setup from the licensee's former nurse. CNS-B further stated the licensee was aware of the required documentation for a medication setup. On September 16, 2026, at 12:10 p.m., CNS-B stated CNS-B was unable to locate documentation of R10's Flexeril medication setup. The licensee's 12.11 Medication Management: Administration and Setup policy dated March 20, 2026, indicated a licensed nurse will set up the medications in dosage boxes or bubble backs for the resident, usually on a weekly basis or may be monthly in bubble packs. The policy did not address documentation of the medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 28 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 interview and record review, the registered nurse (RN) failed to specify, in writing, specific instructions for one of two residents (R3) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 10:17 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided treatment and therapy services to residents. R3's diagnoses included hypertension (HTN- high blood pressure), diabetes, and chronic obstructive pulmonary disease (COPD- difficult breathing).	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 29 R3's Service Plan (Private)- Addendum to Contract dated June 16, 2026, indicated R3's services included support stockings (TEDS- used to reduce swelling in the legs) twice daily. R3's Service Recap Summary- Month dated August 2026, and September 2026, respectively, indicated unlicensed personnel (ULPs) assisted R3 with support stockings in the morning and in the evening. R3's record lacked specific written instructions for ULPs to notify the RN when a problem arises regarding support stockings. On September 16, 2026, at 11:57 a.m., clinical nurse supervisor (CNS)-B stated R3's support stockings lacked parameters of when ULPs were supposed to notify the RN for any problems that may arise. CNS-B further stated R3's support stockings were considered a treatment, and written instructions with parameters were supposed to be documented in R3's record. The licensee's 12.07 Treatment and Therapy: Management Plan policy dated August 11, 2025, indicated site will develop and maintain a current individualized treatment and therapy management record for each resident, which included procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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 30	02320		
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 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 ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-C) observed administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at 10:17 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided medication management services to residents at the facility. On September 15, 2026, at 6:58 a.m., ULP-C	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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 31 stated ULP-C was medication trained and competency tested by the registered nurse (RN) at the facility. R2 R2's diagnoses included retinitis pigmentosa of both eyes (vision loss), diabetes, depression, anxiety with adjustment disorder, and bipolar 1 disorder (extreme shifts in mood, energy, and activity levels). R2's Service Plan (Waiver) - Addendum to Contract dated May 26, 2026, indicated R2's services included med (medication) administration six times per day. R2's prescriber orders dated June 25, 2026, included an order for aspirin 81 milligrams (mg) chewable tablet, chew and swallow one tablet one time a day. R2's Med (medication) Admin (administration) Summary dated September 2026, indicated aspirin low CHW (chew) 81 mg chew one tablet by mouth once daily with food. On September 15, 2026, at 7:00 a.m., the surveyor observed ULP-C provide scheduled morning medication administration for R2. ULP-C compared R2's aspirin label to R2's electronic medication administration record (EMAR), which included instructions to chew one tablet by mouth once daily with food. ULP-C handed R2 a plastic cup containing all R2's scheduled morning medications and a cup of water. R2 swallowed all the provided medications. The surveyor did not observe ULP-C provide R2 instructions to chew the aspirin. On September 15, 2026, at 11:38 a.m., clinical	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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 32 nurse supervisor (CNS)-B stated staff were expected to follow the medication instructions listed on the EMAR. Additionally, CNS-B stated R2's aspirin label indicated it was chewable and expected staff to instruct R2 to chew the aspirin. R4 R4's diagnoses included hyperlipidemia (high cholesterol) and osteoarthritis (painful swollen joints) of knee. R4's Service Plan (Private) - Addendum to Contract dated August 10, 2026, indicated R4's services included med (medication) administration three times per day. R4's prescribers orders dated March 31, 2026, included an order for capsaicin (for arthritis) 0.025% topical. Instructions stated apply thin film to bilateral (both) knees twice daily for pain. R4's Med (medication) Admin (administration) Summary dated September 2026, indicated capsaicin 0.025% with instructions to apply thin film to bilateral knees twice daily for pain. On September 15, 2026, at 7:28 a.m., the surveyor observed ULP-C provide scheduled morning medication administration for R4. ULP-C compared R4's capsaicin label to R4's electronic medication administration record (EMAR), which included instructions to apply thin film to bilateral knees. ULP-C applied capsaicin to R4's right knee. The surveyor did not observe ULP-C apply the capsaicin to R4's left knee. On September 15, 2026, at 1:26 p.m., ULP-C stated capsaicin is typically applied to one of R4's knees. Additionally, ULP-C stated R4's EMAR indicated to apply capsaicin to bilateral knees.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34822	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARDING PLACE	24448 296TH AVENUE PIERZ, MN 56364

(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 33 On September 16, 2026, at 11:46 a.m., CNS-B stated staff were expected to follow medication instructions listed on the EMAR and to apply capsaicin to bilateral knees. The licensee's 12.25 Medication and Treatment: Administration and Delegation policy dated August 11, 2025, indicated an RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' [sic] record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

HARDING PLACE
24448 296th Ave
Pierz, MN 56364
Morisson County
Parcel:

Phone:

License Info

License: HFID 34822

Risk:
License:
Expires on:
CFPM: Tamara Pulak
CFPM #: 69947; Exp: 9/8/2029

Inspection Info

Report Number: F1017261188
Inspection Type: Full - Single
Date: 9/14/2026 Time: 12:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: HOT WATER SANITIZATION WAS ONLY REACHING 150 DEGREES F AT UTENSIL SURFACE TEMPERATURE, MAINTAIN MACHINE TO REACH 160 DEGREES F AT PLATE TEMPERATURE.
Comply By: 9/14/2026 Originally Issued On: 9/14/2026

! **New Order: 5-200B Plumbing: cross connections**
5-203.14 *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.
COMMENT: PROVIDE BACKFLOW PREVENTION DEVICE ON WATER LINE SERVING THE JUICE DISPENSER.
Comply By: 9/14/2026 Originally Issued On: 9/14/2026

Food & Beverage General Comment

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, COOLING TIME AND TEMPERATURE FOR FOOD SAFETY.

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 F1017261188 from 9/14/2026

Tamara Pulak
Manager

Nate Topp,
Public Health Sanitarian 2
320-223-7333
nate.topp@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

HARDING PLACE
Pierz
County/Group: Morisson County

Inspection Info

Report Number: F1017261188
Inspection Type: Full
Date: 9/14/2026
Time: 12:00:00 PM

Food Temperature: Product/Item/Unit: EGG NOODLES **; Temperature Process:** 39
Location: Walk-in Cooler at 39 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

Equipment Temperature: Product/Item/Unit: UPRIGHT COOLER FOR RESIDENTS **; Temperature Process:** Cold-Holding
Location: Ambient at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BACON**; Temperature Process:** Cooking
Location: Flat Top at 236.00 Degrees F.
Comment:
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

HARDING PLACE
Pierz
County/Group: Morisson County

Inspection Info

Report Number: F1017261188
Inspection Type: Full
Date: 9/14/2026
Time: 12:00:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 150 Degrees F.
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1017261188

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: 9/14/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:00 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
HARDING PLACE	24448 296th Ave	Pierz, MN	56364	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 34822		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	N/O	Proper eating, tasting, drinking, tobacco use		
7	N/O	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	OUT	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	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	IN	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		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	X	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)

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34822016-0	**Date:** September 15, 2026
Facility Name: Harding Place	
Facility Address: 24448 296th Avenue, Pierz, MN 56364	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Two (2) 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. An exit access shall not pass through a room that can be locked to prevent egress. [Minn. Stat. 144G.45 subd. 2; MSFC 1016.2]

   Comments: There was an exit sign above the smoking room door, and a keyed lock was installed on this door. Additionally, the smoking room door was identified as an exit on the emergency evacuation floor plans.

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments: When the licensee tested the smoke alarms in pod 4, the smoke alarms were not interconnected. This was corrected while the surveyor was onsite.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **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 cold water faucet was not working in the bathroom of resident pod 3.
   - In the shared resident bathroom, the outer surface of the insulation around one pipe was damaged with exposed fibers.

☒ **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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plan (FSEP) was stored in a locked office. The FSEP was not readily available in the event of an emergency to all building occupants and emergency responders.

2. 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 develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building, templates were used. The FSEP included inaccurate procedures that referenced smoke compartment doors, a basement, and fire doors on magnetic door holders. Smoke zones were referenced but not identified.

3. 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 surveyor requested evacuation procedures for the individualized unique needs of residents from the licensee. The provided emergency binder included resident evacuation reports. These reports assigned each resident an evacuation assistance level, but the specific evacuation procedures for each resident were lacking. Additionally, these procedures were not kept with the fire safety and

evacuation plan and there were no instructions within the FSEP on where these procedures were maintained.

4. 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 surveyor requested records for employee training on the fire safety and evacuation plan (FSEP) completed in the last year from the licensee. The licensee stated these records were not available. Employee FSEP training records were not provided for review when requested. Employee training on the FSEP was not completed at the required frequency.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for resident training on fire safety and evacuation completed in the last year from the licensee. The licensee stated these records were not available. Resident training records were not provided for review when requested. Resident training on fire safety and evacuation was not completed at the required frequency.