Electronically Delivered

August 31, 2026

Licensee
Fair Meadow Assisted Living
300 Garfield Avenue Se
Fertile, MN 56540

RE: Project Number(s) SL29652016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 5, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29652	A. BUILDING: _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW ASSISTED LIVING	300 GARFIELD AVENUE SE FERTILE, MN 56540

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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: SL29652016-0 On August 3, 2026, through August 5, 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.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license effective July 1, 2026, with an expiration date of June 30, 2027. The facility was licensed for a capacity of 25 and had a current census of 20 residents. During the entrance conference on August 3, 2026, at 10:20 a.m., CNS-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Entrance Conference dated August 3, 2026, indicated the following: -day shift 7:00 a.m. through 7:00 p.m. one ULP was scheduled; -day shift 8:00 a.m. through 12:00 p.m. one ULP was scheduled three days per week to assist with basic housekeeping and medications; and -night shift 7:00 p.m. through 7:00 a.m. one ULP was scheduled. During a self-guided tour on August 3, 2026, from 11:30 a.m., through 11:55 a.m., the surveyor observed a daily staff posting on the bulletin board at the assisted living facility. The staff posting indicated the following staff scheduled for August 3, 2026: -one ULP 7:00 a.m. to 7:00 p.m.; -one ULP 8:00 a.m. to 12:00 p.m.; -one ULP 7:00 p.m. to 7:00 a.m.; and	0 470		

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0 470	Continued From page 3 -one registered nurse (RN) available 24 hours per day/seven days per week on call. On August 4, 2026, at 2:25 p.m., CNS-B stated the licensee did not have a staffing plan written out, however, since the building had "been full" and the census had not changed, the staffing schedule has stayed the same for a long period of time. CNS-B further stated the licensee was not aware of the staffing plan regulation. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated August 1, 2021, indicated a CNS, or designee, will develop, write, and implement a staffing plan. The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24- hours a day, seven days a week and will be adequate to address: -each resident's needs as identified in the service plan and assisted living contract; -each resident's acuity level as determined by the most recent assessment or individualized review; -ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; -the staffing plan will indicate if the assisted living has a secured dementia unit; and -staff competency and training. In addition, the policy indicated the staffing plan will be evaluated for the appropriately [sic] of staffing levels in the facility and revised as needed at a minimum of two times per year. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3, effective October 2022, the CNS must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a	0 470		

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0 470	Continued From page 4 week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: (A) each resident's needs, as identified in the resident's service plan and assisted living contract; (B) each resident's acuity level, as determined by the most recent assessment or individualized review; (C) the ability of staff to timely met the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; (D) whether the facility has a secured dementia care unit; and (E) staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 5 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (licensed practical nurse/housing manager (LPN/HM)-E, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 3, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on April 27, 2026, and the facility was determined to be a low risk level.	0 660		

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0 660	Continued From page 6 LPN/HM-E LPN/HM-E was hired on February 25, 2014, and effective August 1, 2021, began to provide direct care services to residents and supervision of staff at the assisted living facility. Throughout the survey on August 3, 2026, through August 5, 2026, the surveyor observed LPN/HM-E provide direct care services to residents and supervision of staff at the facility. LPN/HM-E's employee record contained a negative TB screen and first-step TST administered on February 28, 2014, at 1:35 p.m., and read on March 5, 2014, at 12:00 p.m. (over 72 hours had passed since administration). LPN/HM-E's employee record contained a negative second-step TST administered on March 14, 2014, at 2:00 p.m., and read on March 19, 2014, at 1:35 p.m. (over 72 hours had passed since administration). LPN/HM-E's employee record lacked documentation of a TB screening and a TB blood draw or two step TST within 90 days of employment start date. On August 4, 2026, at 2:09 p.m., CNS-B stated two-step TSTs were done upon hire and prior to direct resident care. CNS-B and LPN/HM-E further stated a TST was administered and read 48-72 hours later. On August 4, 2026, at 3:17 p.m., LPN/HM-E stated LPN/HM-E's TSTs were read more than 72 hours after administration and were not read within the required timeframe. ULP-C	0 660		

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0 660	Continued From page 7 ULP-C was hired on March 16, 2026, to provide direct care services to residents at the assisted living facility. On August 3, 2026, at 11:48 a.m., the surveyor observed ULP-C serve food to residents in the dining room. ULP-C's employee record contained a negative TB screen dated March 16, 2026, and a negative first step TST read on March 18, 2026. ULP-C's employee record included a second step TST administered on April 8, 2026, at 4:00 p.m., and was read on April 10, 2026, however, lacked the time the TST was read. ULP-C's employee record lacked documentation of a TB screening and a TB blood draw or two step TST within 90 days of employment start date. On August 4, 2026, at 2:34 p.m., CNS-B stated CNS-B did not document the time read of ULP-C's second TST. CNS-B further stated CNS-B usually documented the administration and read time of TST. On August 6, 2026, at 2:07 p.m., CNS-B emailed (electronic mail) the surveyor, which included ULP-C's timecard from ULP-C's other place of employment for hours worked on April 10, 2026. ULP-C's timecard indicated ULP-C worked from 7:30 a.m. to 4:00 p.m. on April 10, 2026. The timecard lacked documentation of the time ULP-C's second TST was read. The licensee's undated VII. Tuberculosis policy indicated the TST is read between 48 and 72 hours after administration.	0 660		

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0 660	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with	0 680		

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0 680	Continued From page 9 all the required content defined in Appendix Z. This had the potential to affect 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: During the entrance conference on August 3, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated February 2, 2026, lacked quarterly review of the missing resident plan. On August 5, 2026, at 9:30 a.m., CNS-B stated the missing resident policy was reviewed annually with the full review of the licensee's EPP. CNS-B further stated the licensee was not aware the missing resident plan needed to be reviewed quarterly. The licensee's undated 4.13. Missing Resident policy did not address how often the policy was reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and CNS must review the missing person plan at least quarterly	0 680		

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0 680	Continued From page 10 and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) for three of 10 employees (director of maintenance (DM)-D, housekeeper (HSKPR)-I, registered nurse (RN)-J). This had the potential to affect all residents living within the facility.	01290		

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01290	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 3, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. DM-D DM-D was hired on May 26, 2026, to provide maintenance services around the assisted living facility. On August 3, 2026, at approximately 1:05 p.m. through 1:55 p.m., the surveyor observed DM-D tour the assisted living facility with the Minnesota Department of Health engineer. DM-D's employee record contained a clear background study affiliated to the licensee's skilled nursing facility HFID 460 and not the licensee's HFID 29652. HSKPR-I HSKPR-I was hired on September 27, 2024, to provide housekeeping services at the assisted living facility. HSKPR-I's employee record contained a clear background study affiliated to the licensee's skilled nursing facility HFID 460 and not the	01290		

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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
01290	Continued From page 12 licensee's HFID 29652. RN-J RN-J was hired on January 9, 2026, to provide RN on-call services to residents and staff at the assisted living facility. RN-J was licensed by the Minnesota Board of Nursing on January 12, 2009. RN-J's employee record contained a clear background study affiliated to the licensee's skilled nursing facility HFID 460 and not the licensee's HFID 29652. On August 4, 2026, at 2:05 p.m., CNS-B stated the licensee's human resources office was responsible for completing employee background studies upon hire. CNS-B further stated DM-D, HSKPR-I, and RN-J were current employees at the assisted living facility and were not listed on the licensee's NETStudy 2.0 Roster. CNS-B stated the licensee would still be notified if the above noted employees were to become ineligible to work since human resources had access to the licensee's skilled nursing facility NETStudy 2.0 Roster. The licensee's Assisted Living Orientation - All Staff policy dated August 21, 2021, indicated all employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. The policy did not address background study affiliation. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated August 1, 2021, indicated unlicensed personnel shall meet all required orientation and screening	01290		

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	29652	A. BUILDING: _____ B. WING _____	08/05/2026

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01290	Continued From page 13 requirements prior to providing any service to a home care client (resident). The policy did not address background study affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 14 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 15 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 August 3, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. ULP-C was hired on March 16, 2026, to provide direct care services to residents at the assisted living facility. On August 3, 2026, at 11:48 a.m., the surveyor observed ULP-C serving food to residents in the dining room. ULP-C's employee record contained an undated Educare (online training platform) Transcript, however, ULP-C's employee records lacked the following required orientation topics: -an overview of assisted living statutes 144G; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Managed Care Ombudsman at the Department of Human Services (DHS), county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 16 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 4, 2026, at 2:37 p.m., CNS-B stated the licensee's education department assigns all courses on Educare, and CNS-B was not sure why ULP-C had not completed training with the above noted content. CNS-B further stated CNS-B was aware of required orientation to assisted living topics. The licensee's Assisted Living Orientation- All Staff policy dated August 21, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must include the following topics: -an overview of Minnesota's assisted living law; -principles of person-centered planning and service delivery and how they apply to direct support services; and -complaint process: handling of residents' complaints, the organization's system for receiving and responding to complaints, where and how to report complaints, contact information for the Office of Health Facility Complaints, contact information for the OOLTC, and contact information for the OMHDD. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

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01530	Continued From page 17 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of initial dementia training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living license effective July 1, 2026. During the entrance conference on August 3, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. ULP-C was hired on March 16, 2026, to provide direct care services to residents at the assisted living facility. On August 3, 2026, at 11:48 a.m., the surveyor observed ULP-C serving food to residents in the dining room. ULP-C's employee record contained an undated Educare (online training platform) Transcript,	01530		

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01530	Continued From page 19 which indicated ULP-C had completed 3.75 hours of dementia training. ULP-C's employee record lacked eight hours of initial dementia training completed within 160 hours of working from ULP-C's employment start date. On August 4, 2026, at 2:35 p.m., CNS-B stated the licensee required staff to complete eight hours of initial dementia training prior to providing direct care services to residents at the facility, however, CNS-B was unsure why ULP-C had not completed all required dementia training. CNS-B further stated CNS-B had thought ULP-C had worked more than 160 hours for the licensee. On August 5, 2026, at 9:50 a.m., CNS-B stated the licensee's education department had assigned some of ULP-C's dementia courses in a different language ULP-C was not familiar with, and the education department never reassigned more dementia training with ULP-C's primary language. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated direct-care staff will complete a minimum of 8 (eight) hours initial training on dementia care topics and initial training will be completed within 160 working hours of the employment start date. The licensee's Assisted Living Orientation- All Staff policy dated August 21, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must include dementia training.	01530		

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01530	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (director of maintenance (DM)-D) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01550		

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01550	Continued From page 21 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 August 3, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. DM-D was hired on May 26, 2026, to provide maintenance services around the assisted living facility. On August 3, 2026, at approximately 1:05 p.m. through 1:55 p.m., the surveyor observed DM-D tour the assisted living facility with the Minnesota Department of Health engineer. DM-D's employee record indicated DM-D worked 40 hours per week for the licensee since May 26, 2026. DM-D's employee record included an Educare transcript (online training platform), which indicated DM-D had completed 6.25 hours of dementia training, and 0.5 hours of mental health and de-escalation training August 3, 2026 (date survey initiated), and August 4, 2026 (one day after survey initiated), respectively. DM-D's employee record lacked evidence of four hours of initial dementia training, and two hours of initial training on mental illness and de-escalation within 160 hours of DM-D's employment start date. On August 3, 2026, at 2:31 p.m., CNS-B stated DM-D was employed through the licensee's	01550		

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01550	Continued From page 22 attached skilled nursing facility, however, DM-D maintained the entire building including the assisted living facility. On August 4, 2026, at 2:39 p.m., CNS-B stated DM-D was assigned to complete initial dementia and mental illness training upon hire, however, DM-D had not completed the courses prior to the surveyor requesting to review DM-D's employee record. CNS-B further stated DM-D was considered employed through the licensee's attached skilled nursing facility and not an employee for the assisted living facility. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated non-direct staff will complete a minimum of 4 (four) hours initial training on dementia care topics and initial training will be completed within 120 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
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 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	01620		

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01620	Continued From page 23 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 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 3, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included hypertension (HTN-high blood pressure), arthritis (painful inflammation and stiffness of the joints), and gastroesophageal reflux disease (GERD-acid reflux). R2's Service Plan Level 1 (one) dated July 9, 2026, indicated R2's services included medication administration, application and removal of TEDS (compression stockings used to promote circulation in the legs) as needed, light housekeeping, and laundry. On August 4, 2026, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F put on R2's TEDS.	01620		

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01620	Continued From page 25 R2's (licensee name) Supervisory Visit Notes 90 day were completed January 10, 2026, and April 10, 2026, respectively, however, lacked the following content of the uniform assessment tool: -the resident's personal lifestyle preferences, including: -sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; and -advanced health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. -activities of daily living including: -toileting pattern, bowel, and bladder control; -grooming; -mobility, including ambulation, transfers, and assistive devices; and -eating, dental status, oral care, and assistive devices and dentures, if applicable. - physical health status including: -a review of relevant health history and current health conditions including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -infectious conditions; -a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: -the reason taken; -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues;	01620		

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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
01620	Continued From page 26 -the dosage; -the frequency of use; -the route administered or taken; -any difficulties the resident faces in taking the medication; -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and -provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -weight; and -initial vital signs if indicated by health conditions or medications. -emotional and mental health conditions; -communication and sensory capabilities; -nutritional and hydration status and preference; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: -risk for falls including history of falls; -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -risk for emotional or psychological distress due to personal losses;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29652	A. BUILDING: _____ B. WING _____	08/05/2026

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FAIR MEADOW ASSISTED LIVING	300 GARFIELD AVENUE SE FERTILE, MN 56540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including: - the presence of any advance health care directive or other legal document that establishes a substitute decision maker; -the scope of decision-making authority of a substitute decision maker; and -the need for follow-up referrals for additional medical or cognitive care by health profession On August 5, 2026, at 11:32 a.m., CNS-B stated CNS-B used the uniform assessment tool to complete a resident's initial assessment and annual assessment. CNS-B further stated CNS-B was not aware a uniform assessment was required to be completed on each resident at least every 90 days. CNS-B stated all resident's 90 day assessments lacked the above noted content. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated August 1, 2021, indicated a RN will complete ongoing assessments no less than every 90 days. The comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October	01620		

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FAIR MEADOW ASSISTED LIVING	300 GARFIELD AVENUE SE FERTILE, MN 56540

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01620	Continued From page 28 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the RN who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

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01640	Continued From page 29 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for two of three residents (R3, 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 found to be pervasive). The findings include: During the entrance conference on August 3, 2026, from 10:19 a.m. through 10:36 a.m., the surveyor reviewed the licensee's filled out Entrance Conference dated August 3, 2026. Clinical nurse supervisor (CNS)-B stated CNS-B had filled out the Entrance Conference form prior to the surveyor's arrival, and the Entrance Conference reflected current and accurate information. The Entrance Conference indicated	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 30 a service plan is developed on admission by RN (registered nurse) while including the resident and or family/responsible person. It (service plan) is reviewed annually, after ER (emergency room) visit, hospitalization and or change in condition by the RN also [sic]. R3 R3's diagnoses included chronic kidney disease and mild cognitive impairment. On August 4, 2026, at 8:06 a.m., the surveyor observed ULP-F put on R3's Circaid wraps (compression wraps used on the lower legs to reduce swelling). R3's prescriber orders dated July 1, 2026, included an order for PT/OT (physical therapy/occupational therapy) evaluation and treatment including the use of Circaid wraps. R3's Client (resident) Treatment or Therapy Management Plan dated July 30, 2026, indicated to apply R3's Circaid wraps in the morning and remove R3's Circaid wraps in the evening. R3's (licensee name) Service Chart for (R3's name) dated July 2026, indicated R3's Circaid wraps were applied in the morning and removed in the evening effective July 30, 2026. R3's Service Plan Attachment D to Resident Contract dated July 1, 2026, lacked application and removal of R3's Circaid wraps daily. R5 R5's diagnoses included diabetes, hypertension (HTN-high blood pressure), and heart failure. On August 4, 2026, at 11:17 a.m., the surveyor	01640		

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01640	Continued From page 31 observed ULP-F complete a blood glucose check for R5. R5's prescriber orders dated June 23, 2026, included an order for blood glucose checks three times per day. R5's Treatment Administration Record dated July 2026, and August 2026, respectively, indicated R3 received blood glucose checks three times per day. R5's Service Levels Attachment B of Residency/Service Agreement/Service Plan dated September 17, 2025, lacked blood glucose checks three times per day. On August 5, 2026, at 11:56 a.m., CNS-B stated CNS-B listed R3's Circaid wraps and R5's blood glucose checks on the treatment plan. CNS-B further stated CNS-B considered the treatment plan an addendum to each resident's service plan. CNS-B stated CNS-B was not sure why some treatments were listed on resident service plans and other treatments were not. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional [sic]. In addition, service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01650	Continued From page 32	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for one of one resident (R5).	01650		

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01650	Continued From page 33 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: During the entrance conference on August 3, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R5's diagnoses included diabetes, hypertension (HTN-high blood pressure), and heart failure. R5's Service Levels Attachment B of Residency/Service Agreement/Service Plan dated September 17, 2025, indicated R5's services included medication administration, bathing, grooming, dressing, light housekeeping, and laundry. On August 4, 2026, at 11:17 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R5. R5's service plan indicated the schedule of monitoring assessments of the resident, and the schedule of monitoring staff providing services. R5's service plan lacked the methods of monitoring assessments of the resident, and the methods of monitoring staff providing services per assisted living regulations.	01650		

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01650	Continued From page 34 On August 5, 2026, at 11:29 a.m., CNS-B stated all resident service plans used the same template. CNS-B further stated resident assessments and supervision of staff were completed in person, however, resident service plans did not have the method listed on how assessments and supervision of staff were completed. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated the service plan will include the schedule and methods of monitoring assessments, and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01770 SS=F	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 one resident (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	01770		

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01770	Continued From page 35 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: During the entrance conference on August 3, 2026, from 10:19 a.m. through 10:36 a.m., the surveyor reviewed the licensee's filled out Entrance Conference dated August 3, 2026. Clinical nurse supervisor (CNS)-B stated CNS-B had filled out the Entrance Conference form prior to the surveyor's arrival, and the Entrance Conference reflected current and accurate information. The Entrance Conference indicated the licensee provided medication management services to residents at the facility. R2's diagnoses included hypertension (HTN-high blood pressure), arthritis (painful inflammation and stiffness of the joints), and gastroesophageal reflux disease (GERD-acid reflux). R2's Service Plan Level 1 (one) dated July 9, 2026, indicated R2's services included medication setup every other week, and medication administration twice per day. R2's prescriber orders dated July 28, 2026, included the following orders: -Allopurinol (for gout) 100 milligrams (mg) twice daily; -aspirin (for heart health) 81 mg daily; -ferrous sulfate (supplement) 325 mg daily; -hydrochlorothiazide (for swelling) 25 mg daily; -Imodium A-D (for diarrhea) 2 mg three times daily;	01770		

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01770	Continued From page 36 -Klor-Con M10 (for HTN) 10 milliequivalents (mEq) two tablets daily; -Lasix (for HTN) 20 mg every other day; -Norvasc (for HTN) 5 mg daily; -Protonix (for GERD) 40 mg daily; and -Toprol XL (for a fast heart rate) 50 mg daily. On August 4, 2026, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R2's scheduled morning medication. ULP-F removed R2's medication deck (multi-compartment device used to setup medications to be given on a certain day and/or time) out of R2's locked medication cupboard, removed R2's medication from the Tuesday morning slot, and administered the medication to R2. R2's (licensee name) Service Chart for (R2's name) dated July 2026, indicated R2's medications were setup every other week in a medication deck. R2's record contained documentation of a medication setup completed by licensed practical nurse (LPN)-H on July 1, July 15, and July 29, respectively, however, R2's record lacked documentation for 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, and route of administration. On August 5, 2026, at 10:53 a.m., LPN-H stated LPN-H completed medication setups every other week for residents and documented the medication setups on the resident's service charts. On August 5, 2026, at 11:40 a.m., CNS-B stated LPN-H completed medication setups every other	01770		

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01770	Continued From page 37 week for residents and documented the medication setups on the service charts. CNS-B further stated LPN-H documented the medication setups the same way for all residents, and the documentation did not include the name of the medication, quantity of dose, times to be administered, and route of administration. Licensed practical nurse/housing manager (LPN/HM)-E stated the licensee used to document the medication setup with required content previously, however, was not sure when the medication setup documentation had been changed. The undated Medication Management Services policy indicated when setting up medication for later administration the RN (registered nurse) or LPN will: -verify that the dose and quantity of medications delivered is consistent with the prescription; -review prescribed medications to identify any contraindications or other concerns; -identify whether refills are needed and follow up to be sure the refill is available when needed; and -verify that medications for the previous period were administered as prescribed. If the nurse identifies any discrepancies or concerns when setting up medications, the nurse will complete appropriate follow up and documentation of the results of the follow up. The policy did not address medication setup documentation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01910	Continued From page 38	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	01910		

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01910	Continued From page 39 situation has occurred only occasionally). The findings include: During the entrance conference on August 3, 2026, from 10:19 a.m. through 10:36 a.m., the surveyor reviewed the licensee's filled out Entrance Conference dated August 3, 2026. Clinical nurse supervisor (CNS)-B stated CNS-B had filled out the Entrance Conference form prior to the surveyor's arrival, and the Entrance Conference reflected current and accurate information. The Entrance Conference indicated the licensee provided medication management services to residents at the facility. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated August 3, 2026, indicated R1 was admitted to the facility on July 29, 2024, and discharged on June 10, 2026. R1's diagnoses included diabetes, chronic kidney disease, and mild cognitive impairment. R1's Service Plan dated April 1, 2025, indicated R1 received medication administration twice daily. R1's Medication Administration Record (MAR) dated June 2026, indicated R1 received the following medications: -aspirin (for heart health) 81 milligrams (mg) daily -escitalopram oxalate (antianxiety) 20 mg daily -Januvia (for diabetes) 100 mg daily -metformin HCl ER (for diabetes) 500 mg daily -Zocor (for high cholesterol) 20 mg daily -Zyprexa (for dementia) 5 mg daily R1's prescriber orders dated June 9, 2026, included the above noted medications.	01910		

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01910	Continued From page 40 R1's Discharge Summary dated June 10, 2026, indicated R1 was discharged to the licensee's sister skilled nursing facility. In addition, medications were reconciled and brought to the Nursing Home Medication Nurse. R1's Record of Inventory and Destruction of Controlled and Uncontrolled Substances dated April 10, 2026, had the following entry written by CNS-B: -June 10, 2026: Current med (medication) packs sent with (resident's name) to (skilled nursing facility name). Will cont (continue) with med (medication) exchange via (pharmacy name). R1's record lacked the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition for the medications noted above. On August 4, 2026, at 2:20 p.m., CNS-B stated since R1's medications went with R1 via medication exchange (prescription cycles automatically filled by the pharmacy) CNS-B did not count each medication as R1 would continue to receive prescriptions, via the medication exchange, at the skilled nursing facility. CNS-B further stated CNS-B did not document the medication disposition for the medications noted above. CNS-B stated the licensee was aware of medication disposition documentation and had documented all requirements for the destruction of medications. The licensee's Disposition or Disposal of Medication policy dated August 1, 2021, indicated staff will document in the client's (resident's) record the name of the person to whom the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29652	A. BUILDING: _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW ASSISTED LIVING	300 GARFIELD AVENUE SE FERTILE, MN 56540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 41 medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FAIR MEADOW ASSISTED LIVING	300 GARFIELD AVENUE SE FERTILE, MN 56540

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01930	Continued From page 42 with current practice standards and guidelines. 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: During the entrance conference on August 3, 2026, from 10:19 a.m., through 10:36 a.m., the surveyor reviewed the licensee's filled out Entrance Conference dated August 3, 2026. Clinical nurse supervisor (CNS)-B stated CNS-B had filled out the Entrance Conference form prior to the surveyor's arrival, and the Entrance Conference reflected current and accurate information. The Entrance Conference indicated the licensee provided treatment management services to residents at the facility. On August 4, 2026, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F put on R2's TEDS. The treatment and therapy policies provided did not include policies to address the following: -requesting and receiving orders or prescriptions for treatments or therapies; -educating and communicating with residents about treatments or therapies they are receiving; -monitoring and evaluating the treatment or therapy; and -communicating with the prescriber.	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01930	Continued From page 43 On August 4, 2026, at 12:40 p.m., the surveyor requested to review the licensee's individualized treatment and therapy plan policy with required content from CNS-B. On August 5, 2026, at 1:02 p.m., the surveyor requested CNS-B to email (electronic mail) a copy of the licensee's individualized treatment and therapy plan policy with required content. On August 6, 2026, at 2:34 p.m., the surveyor emailed CNS-B requesting to review the licensee's individualized treatment and therapy plan policy with required content. The surveyor confirmed CNS-B had sent the blank template for individualized treatment plan, however, the surveyor did not receive the individualized treatment and therapy plan policy. On August 6, 2026, at 5:28 p.m., CNS-B emailed the surveyor another copy of the blank template for individualized treatment plan. The surveyor did not receive any additional policies from the licensee. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01930		
01950 SS=E	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	01950		

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01950	Continued From page 44 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, specific instructions for two of three residents (R2, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 3, 2026, from 10:19 a.m. through 10:36 a.m., the surveyor reviewed the licensee's filled out Entrance Conference dated August 3, 2026.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 45 Clinical nurse supervisor (CNS)-B stated CNS-B had filled out the Entrance Conference form prior to the surveyor's arrival, and the Entrance Conference reflected current and accurate information. The Entrance Conference indicated the licensee provided treatment management services to residents at the facility. R2 R2's diagnoses included hypertension (HTN-high blood pressure), arthritis (painful inflammation and stiffness of the joints), and gastroesophageal reflux disease (GERD-acid reflux). R2's Service Plan Level 1 (one) dated July 9, 2026, indicated R2's services included application and removal of TEDS (compression stockings used to promote circulation in the legs) as needed. R2's Client (resident) Treatment or Therapy Management Plan dated July 9, 2026, indicated to apply R2's TEDS in the morning and remove R2's TEDS in the evening. R2's prescriber orders dated June 8, 2026, included orders for TEDS. R2's (licensee name) Service Chart for (R2's name) dated June 2026, and July 2026, respectively, indicated R2's TEDS were applied in the morning and removed in the evening. On August 4, 2026, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F put on R2's TEDS. R2's record lacked specific instructions for ULPs to notify the RN when a problem arises regarding R2's TEDS.	01950		

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01950	Continued From page 46 On August 5, 2026, at 11:50 a.m., CNS-B stated ULPs were trained on when to notify the RN with Educare (online training platform), however, CNS-B stated R2's record lacked specific written instructions for ULPs to notify the RN when a problem arose with R2's TEDS, and CNS-B was not sure why written instructions were not listed. R3 R3's diagnoses included chronic kidney disease and mild cognitive impairment. R3's Service Plan Attachment D to Resident Contract dated July 1, 2026, lacked application and removal of R3's Circaid wraps (compression wraps used on the lower legs to reduce swelling). R3's Client (resident) Treatment or Therapy Management Plan dated July 30, 2026, indicated to apply R3's Circaid wraps in the morning and remove R3's Circaid wraps in the evening. R3's prescriber orders dated July 1, 2026, included an order for PT/OT (physical therapy/occupational therapy) evaluation and treatment including the use of Circaid wraps. R3's (licensee name) Service Chart for (R3's name) dated July 2026, indicated R3's Circaid wraps were applied in the morning and removed in the evening effective July 30, 2026. On August 4, 2026, at 8:06 a.m., the surveyor observed ULP-F put on R3's Circaid wraps. R3's record lacked specific instructions for ULPs to notify the RN when a problem arises regarding R3's Circaid wraps.	01950		

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01950	Continued From page 47 On August 5, 2026, at 11:50 a.m., CNS-B stated CNS-B trained ULPs on R3's Circaid wraps, however, CNS-B did not document written specific instructions in R3's record of when to notify the RN when a problem arose with R3's Circaid wraps. CNS-B further stated CNS-B had typically written in specific instructions for treatments such as blood glucose or oxygen. The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated August 1, 2021, indicated the RN may delegate administration of treatment if the ULP have [sic] satisfied the training requirements, and if the RN has developed written, specific instruction for each client (resident). The licensee lacked an individualized treatment plan policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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02310	Continued From page 48 health care and medical, or nursing standards for one of one resident (R2) with a consumer bedrail. 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: During the entrance conference on August 3, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included hypertension (HTN-high blood pressure), arthritis (painful inflammation and stiffness of the joints), and gastroesophageal reflux disease (GERD-acid reflux). On August 4, 2026, at 7:17 a.m., the surveyor observed an upper consumer bedrail on the left side of R2's bed. The consumer bedrail was a black upside-down U shape. Unlicensed personnel (ULP)-F stated R2 used the consumer bedrail to sit up in bed. R2's Service Plan Level 1 (one) dated July 9, 2026, indicated R2's services included medication administration, application and removal of TEDS (compression stockings used to promote circulation in the legs) as needed, light housekeeping, and laundry. R2's Bed Rail Education Acknowledgment Form	02310		

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02310	Continued From page 49 dated July 5, 2024, indicated the risk and benefits of the bedrail rail and other potential alternatives to be used instead of the bedrail were discussed with R2 and R2's representative. R2's Side Rail (bedrail) Screen dated April 14, 2026, June 1, 2026, and July 9, 2026, respectively, indicated the following: -R2 was alert and oriented; -R2's bedrail was used effectively for repositioning; -R2 was unable to reposition without the use of the bedrail; -R2 expressed desire to have the bedrail on R2's bed; -R2 demonstrated proper use of the bedrail; -R2 had a history of falls form R2's bed; -R2 had difficulty with sitting balance; -R2 had difficulty with standing balance; -R2 took medications that required increased safety precautions; and -PT/OT (physical therapy/occupational therapy) recommended the bedrail for R2. R2's (licensee name) Service Chart for (R2's name) dated June 2026, and July 2026, respectively, indicated safety checks were completed on R2's bedrail daily to ensure the bedrail was secured to the bed frame, the bedrail was flush with the mattress, and R2 only used the bedrail for bed mobility. In addition, report loose or damaged bedrails to the nurse. R2's Supervisory Visit Notes dated January 10, 2026, and April 10, 2026, respectively, indicated R2's Care Plan/Service Plan had been reviewed and no changes were required. R2's record lacked evidence the licensee referred to the Consumer Product Safety Commission	02310		

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02310	Continued From page 50 (CSPC) for bedrail recall information at least every 90 days with the requirement included in the uniform assessment tool for assessing assistive devices. On August 5, 2026, at 11:38 a.m., CNS-B stated all residents with a consumer bedrail used the same exact bedrail throughout the assisted living facility and the licensee's maintenance department completed installation, measurements, and monitoring of the bedrails. CNS-B further stated the maintenance department maintained the copy of the manufacturer's instructions of the bedrail and monitored for recalls. CNS-B further stated R2's bed rail was not used as a restraint. On August 5, 2026, at 12:07 p.m., CNS-B stated the licensee lacked documentation of the consumer bedrail being checked quarterly on the CSPC website and CNS-B was not aware of the requirement to be completed quarterly. The licensee's Side Rails policy dated September 8, 2022, indicated the registered nurse (RN) will assess and evaluation [sic] what the resident's needs are and assess to determine if the resident can safely utilize the siderail/equipment. Maintenance will measure the mattress and side rail and see If it meets the FDA (Food and Drug Administration) standards for side rails. The policy did not address how often to check the CSPC website for recalls. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated August 1, 2021, indicated a comprehensive assessment, completed by the RN, includes but may not be limited to the requirements outlined by	02310		

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02310	Continued From page 51 Minnesota rules. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 17, 2026, indicated licensees should review the CSPC website regularly for updates on recalled portable (consumer) bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Fair Meadow
300 GARFIELD AVENUE SE
Fertile, MN 56540
Polk County
Parcel:

Phone:

License Info

License: HFID 29652

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

Inspection Info

Report Number: F1049261138
Inspection Type: Full - Single
Date: 8/4/2026 Time: 11:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTOR MET WITH ESTABLISHMENT REPRESENTATIVE AND MDH NURSE EVALUATOR, SARA UMLAUF.

DISCUSSED:
-EMPLOYEE ILLNESS LOG
-VOMIT CLEAN UP PROCEDURE

ALL MEALS ARE PREPPED AND COOKED IN THE NURSING HOME KITCHEN AND SERVED OUT OF THE ASSISTED LIVING'S SERVING KITCHEN. ALL UTENSILS AND DISHES ARE BROUGHT TO THE NURSING HOME KITCHEN TO BE PROPERLY CLEANED AND SANITIZED.

THE SERVING KITCHEN HAD VINYL PLANKING FLOOR, PAINTED WALLS AND CEILING, LAMINATE COUNTERTOPS, SMOOTH CUPBOARDS, AND NON-ANSI CERTIFIED EQUIPMENT.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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 Fergus Falls District Office inspection report number F1049261138 from 8/4/2026

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Fair Meadow
Fertile
County/Group: Polk County

Inspection Info

Report Number: F1049261138
Inspection Type: Full
Date: 8/4/2026
Time: 11:15 AM

Food Temperature: Product/Item/Unit: 2% Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 36.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BBQ Meat**; Temperature Process:** Hot-Holding
Location: Steam Table at 184 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed Potatoes**; Temperature Process:** Hot-Holding
Location: Steam Table at 142 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cucumber in Ranch**; Temperature Process:** Cold-Holding
Location: Serving Line at 41 Degrees F.
Comment:
Violation Issued?: No