Electronically Delivered

January 28, 2026

Licensee
South Grove Lodge Senior Living
1701 22nd Avenue Southwest
Austin, MN 55912

RE: Project Number(s) SL30819016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 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 . . ."

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH GROVE LODGE SENIOR LIVING	1701 22ND AVENUE SW AUSTIN, MN 55912

(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: SL30819016-0 On January 12, 2026, through January 14, 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 46 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=C	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 staffing schedule was posted with the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect all residents, staff, and visitors. 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)	0 470		

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0 470	Continued From page 2 and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an Assisted Living license for a bed capacity of 85 residents. At the time of the survey, there were 46 residents; 20 receiving services under the Assisted Living Facility license. During the entrance conference on January 12, 2026, at 11:25 a.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated the staffing shift hours were as follows: Day shift: two unlicensed personnel (ULP) 6:00 a.m. - 2:30 p.m. Evening shift: two ULP 2:00 p.m. - 10:30 p.m., and one ULP 4:00 p.m. - 9:00 p.m., Night shift: two ULP 10:00 p.m. - 6:30 a.m. On January 12, 2026, at 2:35 p.m., the surveyor observed the daily staff schedule posted in a glass case near front entrance. The posting included the date with titles Morning, Evening, and Night, and names of the ULPs. The schedule did not indicate the specific times of each shift. On January 12, 2026, at 3:45 p.m., CNS/ALDIR-A stated the staff posting lacked the hours of work for each staff member. CNS/ALDIR-A further stated she was not aware of the requirement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective January 13, 2025, the CNS must develop a 24-hour daily staffing schedule. The schedule must:	0 470		

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0 470	Continued From page 3 (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's Staffing Plan and Postings policy dated August 24, 2021, noted the 24-hour daily staffing schedule must: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 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	0 480		

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0 480	Continued From page 4 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 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.	0 480		

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0 480	Continued From page 5 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 January 13, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 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	0 680		

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0 680	Continued From page 6 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 evaluate it's missing person policy at least quarterly as per Minnesota Rules Chapter 4659.0110 Subp. 4. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 680		

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0 680	Continued From page 7 The licensee's Missing/Elopement Resident Drill policy revised April 19, 2022, and undated Missing Resident Checklist, was included in the Emergency Preparedness (EP) plan dated as reviewed April 11, 2025. The policy lacked evidence the assisted living director and clinical nurse supervisor reviewed or updated the policy and documented any changes, at least quarterly as required. On January 14, 2026, at 1:00 p.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated the missing resident policy had not been reviewed or updated quarterly as required. CNS/ALDIR-A indicated she was aware of the requirement and had brought this up to her corporate office, but nothing had been implemented yet. The licensee's Emergency and Disaster Plans policy dated August 1, 2021, did not include information on review of missing resident plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 8 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 14, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=D	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	01290		

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01290	Continued From page 9 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license health facility identification number (HFID) for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B began providing assisted living services on December 23, 2024. ULP-B's employee record contained a Background Study Clearance form dated	01290		

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01290	Continued From page 10 December 27, 2024, for HFID 30228 (a separate location operated by the licensee's owner). ULP-B's employee record lacked evidence the licensee affiliated a background study for their current assisted living license HFID 30819. On January 12, 2026, at 2:41 p.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated ULP-B's background study had not been affiliated with the assisted living facility license HFID. The licensee's Background Checks policy dated August 24, 2021, noted all employees with direct resident contact would undergo a background study through Department of Human Services (DHS). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected	01620		

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01620	Continued From page 11 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01620		

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	30819	A. BUILDING: _____ B. WING _____	01/14/2026

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01620	Continued From page 12 (RN) completed ongoing resident reassessments that did not exceed 90 days for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: R2 R2 began receiving assisted living services on August 15, 2025. R2's Individual Service Plan dated December 20, 2025, indicated R2 received services including bathing, dressing, catheter assistance, TED (thromboembolism deterrent) compression socks, blood sugar checks daily, housekeeping, laundry, and medication administration. R2's record included an initial (admission) assessment dated August 15, 2025, a 14-day assessment dated September 24, 2025, and a quarterly assessment dated January 9, 2026. The 14-day assessment was 40 days from the date of the initial assessment, thus exceeding 14 calendar days. In addition, the January 9, 2026, quarterly assessment was 107 days from the date of the previous assessment, thus exceeding 90 calendar days. R4	01620		

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01620	Continued From page 13 R4 began receiving assisted living services on June 24, 2025. R4's Individual Service Plan dated October 12, 2025, indicated R4 received assistance with bathing, grooming, housekeeping, laundry, and medication administration. R4's record included an initial (admission) assessment dated June 24, 2025, a 14-day assessment dated July 15, 2025, and a quarterly assessment dated October 16, 2025. The 14-day assessment was 21 days from the date of the initial assessment, thus exceeding 14 calendar days. In addition, the October 16, 2025, quarterly assessment was 93 days from the date of the previous assessment, thus exceeding 90 calendar days. On January 13, 2026, at 11:45 a.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated the above-named assessments were late. CNS/ALDIR-A further stated she had gotten behind on the assessments and had recently hired another registered nurse to assist. The licensee's Nursing Assessments policy dated revised July 29, 2022, indicated a registered nurse (RN) would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: b. 14-day assessment completed up to 14-days after start of services; and c. Ongoing assessment completed periodically but no less than every 90-days. No further information provided.	01620		

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01620	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 interview and record review, the	01650		

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01650	Continued From page 15 licensee failed to ensure a service plan included the required content for two of two residents (R1, 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 potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included diabetes. R1's Individual Service Plan dated December 15, 2025, indicated R1 received assistance with bathing, blood sugar checks, laundry, light housekeeping, and medication management. R2 R2's diagnoses included diabetes and anxiety. R2's Individual Service Plan dated December 20, 2025, indicated R2 received services including bathing, dressing, catheter assistance, TED (thromboembolism deterrent) compression socks, blood sugar checks daily, housekeeping, laundry, and medication administration. R1 and R2's service plans lacked the following content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 16 - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - 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. On January 13, 2026, at 11:12 a.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated the individual service plan lacked the required content. CNS/ALDIR-A stated there was an additional service plan form that contained the above missing content, and she had not been aware it was to be completed upon admission. In addition, CNS/ALDIR-A stated any of the admissions she had completed in the last 11 months would be missing this. The licensee's Service Plan Contents policy dated revised July 29, 2022, noted the service plan would include: e. Schedule and methods of monitoring assessments f. Schedule and methods of monitoring staff providing services g. Contingency plan h. A contingency plan that includes: - Action taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 17 - Information and method to contact the community; - Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition; - Identification of and information on who has authority to sign for the resident in an emergency; - How the community will support documented resident health care directive decisions, if any-including circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for two of four residents (R4, R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 18 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: R4 R4's diagnoses included glaucoma (eye disease). R4's Individual Service Plan dated October 12, 2025, included medication administration. R4's prescriber orders dated January 7, 2026, included: - prednisolone 1% (steroid eye drop to alleviate eye pain and inflammation) one drop three times per day in left eye for two weeks, then twice daily to left eye for next two weeks. R4's medication administration record (MAR) dated January 7, 2026, through January 13, 2026, included the medication as ordered above. On January 13, 2026, at 7:33 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R4. The prednisolone 1% eye drop had a label that directed to administer one drop four times daily. When interviewed at this time, ULP-B stated the label for R4's prednisolone 1% eye drop did not match the MAR but said she would follow the MAR instead of the label. R1	01890		

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01890	Continued From page 19 R1's diagnoses included diabetes. R1's Individual Service Plan dated December 15, 2025, included medication administration. R1's prescriber orders dated July 15, 2025, included: - cholecalciferol (supplement) 25 micrograms (mcg) by mouth daily. R1's MAR dated January 1, 2026, through January 12, 2026, included the medication as ordered above. On January 14, 2026, at 7:50 a.m., the surveyor observed ULP-B administer medications to R1. The cholecalciferol 25 mcg bottle had a label that directed to administer two tablets once daily. ULP-B stated the label for R1's cholecalciferol did not match the MAR but said she would follow the MAR and alert the nurse indicating the medication label should match the MAR. On January 14, 2026, at 8:36 a.m. clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated there should have been a direction change sticker on the medication labels. CNS/ALDIR-A further stated the prescription label should match the current prescriber orders and MAR. The licensee's Storage and Handling Medications policy dated August 24, 2021, noted: 2b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's	01890		

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01890	Continued From page 20 (resident) name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 the disposition of the medication including the medication strength and prescription numbers	01910		

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01910	Continued From page 21 as applicable, for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's discharged resident roster dated January 12, 2026, indicated R3 discharged on October 24, 2025, to another facility. R3's record included an untitled form with columns that identified the date, resident name, medication, amount and staff initials. The document did not include a column for the prescription number and did not identify to whom the medications were given to or if they were destroyed. - The following medication was listed without a strength: docusate sodium (stool softener); - The following medications were listed without a prescription number: lisinopril (for blood pressure), gabapentin (anticonvulsant), pantoprazole (for excess stomach acid), buspirone (for anxiety), and sertraline (for depression). On January 12, 2026, at 1:40 p.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated R3 received medication management services, and an old form had been utilized which lacked the required components for	01910		

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01910	Continued From page 22 disposition. CNS/ALDIR-A further stated the prescription numbers were not listed and acknowledged the docusate sodium strength was missing on the form, indicating it should have been included. The licensee's Disposition or Disposal of Medication policy dated August 24, 2021, noted documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=D	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 care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R2) with siderails. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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02310	Continued From page 23 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 13, 2026, at 12:44 p.m., the surveyor interviewed R2 in her room. R2 had a standard hospital bed with bilateral top siderails in the upright position. The siderails were firm and secure when grabbed by the surveyor. R2 stated she used the siderails to assist in her bed mobility. R2 began receiving services on August 15, 2025, under the facility's Assisted Living Facility license with a diagnosis of diabetes and anxiety. R2's Individual Service Plan dated December 20, 2025, indicated R2 received services including bathing, dressing, catheter assistance, TED (thromboembolism deterrent) compression socks, blood sugar checks daily, housekeeping, laundry, and medication administration. R2's record included a Supportive Devices Assessment dated December 20, 2025, which indicated R2 utilized a 1/4 siderail. The assessment indicated risk versus benefit was discussed; however, the document did not include evidence that siderail measurements were completed. On January 14, 2026, at 8:45 a.m. clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated she had assessed R2's	02310		

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02310	Continued From page 24 bedrails; however, she did not measure the bed rail zones of entrapment as required. The licensee's Supportive Devices policy dated revised December 12, 2022, indicated an assessment must be completed by a licensed nurse prior to implementing any supportive device. The policy did not direct to complete measurements of the siderails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) as of January 21, 2026, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

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02310	Continued From page 25 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

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

Food & Beverage Inspection Report

Establishment Info

South Grove Lodge Senior Living
1701 22nd Ave SW
Austin, MN 55912
Mower County
Parcel:

Phone: 507434-0600
Ashley.VanRiper@SinceriSL.com

License Info

License: HFID 30819
Ashley VanRiper
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1038261007
Inspection Type: Full - Single
Date: 1/13/2026 Time: 11:12:10 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 8-300 License to Operate
8-301.11A *Priority Level: Priority 2 CFP#: 58*
MN Rule 4626.1755A Discontinue operating the food establishment until a license to operate is obtained from the regulatory authority.
COMMENT:
CATERER (TAKE THE CAKE) DOES NOT HAVE THE CORRECT LICENSE TO OPERATE AS A CATERER
Comply By: 1/19/2026 Originally Issued On: 1/13/2026

Food & Beverage General Comment

MAIN KITCHEN WAS UNDERGOING A REMODEL AND A CATERING SERVICE IS BEING USED TO SERVE FOOD

NO FOOD WAS AVAILABLE TO TEMP.

DISHES WERE CLEANED OF SITE

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

I acknowledge receipt of the Rochester District Office inspection report number F1038261007 from 1/13/2026

Tamara Jefferson
Kitchen Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL30819016	**Date:** 1/14/2026
Facility Name: South Grove Senior Living	
Facility Address: 1701 22nd Ave. SW Austin, MN 55912	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

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

   Comments: The kitchen door was propped open and the sprinkler riser room door had its closure removed.

3. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: In the kitchen C-Wing, a cover is missing on the receptacle and a wire was hanging out from the wall.

4. Maintaining protection. Materials and firestop systems used to protect membrane and through penetrations in fire-resistance-rated construction and construction installed to resist the passage of smoke shall be maintained. The materials and firestop systems shall be securely attached to or bonded to the construction being penetrated with no openings visible through or into the cavity of the construction. Where the system design number is known, the system shall be inspected to the listing criteria and manufacturer's installation instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 703.1]

   Comments: The were holes observed in the rated ceiling in the elevator equipment room, (C-Wing) main kitchen and fire sprinkler riser room.

5. Fire sprinklers and fire detectors, ceilings. In buildings protected by automatic sprinklers or automatic fire detectors, suspended or removable ceiling tiles shall be maintained in place to prevent the delay in sprinkler or detector activation. [Minn. Stat. 144G.45 subd. 2; MSFC 901.11]

Comments: There was a ceiling tile missing in the Pub Room.