DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 2, 2026

Licensee
Moorhead Manor
1710 13th Avenue North
Moorhead, MN 56560

RE: Project Number(s) SL30439016

Dear Licensee:

On September 29, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 8, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie de Palma Jones, Supervisor
State Evaluation Team
Email: Stephanie.Jones.de.Palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Electronically Delivered

August 12, 2026

Licensee
Moorhead Manor
1710 13th Avenue North
Moorhead, MN 56560

RE: Project Number(s) SL30439016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 8, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30439	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

(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: SL30439016-0 On July 6, 2026, through July 8, 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 17 residents; 17 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-F, ULP-E). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 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 July 6, 2026, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee records. ULP-F ULP-F was hired on September 12, 2006, and and began to provide direct assisted living services to the residents at the facility effective August 1, 2021. On July 7, 2026, at 7:48 a.m., the surveyor observed ULP-F complete a blood glucose check for R3 using R3's Libre (a device used to measure blood glucose levels in the blood continuously). ULP-F stated R3 had just begun using the Libre device and staff were trained and competency tested by the registered nurse (RN). ULP-E ULP-E was hired on October 17, 2025, to provide direct assisted living services to residents at the facility. ULP-F and ULP-E's employee records lacked documentation of training and competency testing for R3's Libre. On July 7, 2026, at 8:59 a.m., clinical nurse	0 650		

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0 650	Continued From page 5 supervisor (CNS)-B stated R3 had begun to use the Libre July 1, 2026, and the licensee's other RN had completed training and competency testing for ULPs on the Libre. CNS-B further stated CNS-B usually placed a copy of training and competency testing in employee records, however, CNS-B was not sure if the other RN had completed the documentation for employee records and CNS-B would have to look. On July 8, 2026, at 10:26 a.m., CNS-B stated CNS-B was unable to locate training and competency testing for the Libre in employee records. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person will include verification of completed orientation and annual training and competency testing as required [sic], Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the	0 650		

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0 650	Continued From page 6 instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a	0 660		

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0 660	Continued From page 7 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 one of three employees (registered nurse (RN)-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 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 July 6, 2026, at 9:02 a.m., licensed assisted living director (LALD)-A 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 August 1, 2025, and the facility was determined to be a low risk level. RN-C was hired on December 20, 2024, to provide direct care services to residents and supervision of staff at the assisted living facility. RN-C's employee record contained a negative TB screen and first step TST dated December 19, 2024. RN-C's employee record included a second step TST administered on January 13, 2025, at 6:00 p.m., and was read on January 15, 2025,	0 660		

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0 660	Continued From page 8 however, lacked the time the second TST was read. RN-C's TST form indicated to document the date and time read of each TST and results are read between 48 to 72 hours after administration. RN-C's employee record lacked a second TST, or other evidence of TB screening such as a blood draw, with documentation to verify RN-C's second TST was read within 48 to 72 hours after administration. On July 7, 2026, at 8:54 a.m., LALD-A stated the licensee's process was to send new employees to the public health office to complete a two-step TST and a new employee would not start providing services until the two-step TST was completed. On July 8, 2026, at approximately 10:45 a.m., LALD-A stated RN-C had started employment at another facility at the same time RN-C started for the licensee and had completed the two step TST at the other facility. LALD-A further stated RN-C's second step TST lacked the time the TST was read. LALD-A stated LALD-A had to reach out to RN-C to see if the other facility had documentation of the time RN-C's second TST was read, however, no further information was provided to the surveyor. The licensee's 8.16 TB Screening policy dated August 1, 2021, indicated new staff will have an IGRA (Interferon-Gamma Release Assay) blood test or two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs (health care workers). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 9 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license.	0 680		

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0 680	Continued From page 10 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 July 6, 2026, at 9:02 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated March 14, 2026, lacked the following required content: - quarterly review of the missing resident plan (last reviewed June 1, 2025); - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 needed. On July 8, 2026, at 11:48 a.m., LALD-A stated LALD-A was not sure if the licensee's missing resident policy was reviewed quarterly. LALD-A further stated the licensee had participated in a virtual table-top exercise in September 2025, however, LALD-A would have to look for documentation of the 2025 exercises. On July 8, 2026, at 12:20 p.m., LALD-A stated the licensee had not reviewed the missing resident policy since June 2025. LALD-A further stated the licensee was looking for copies of the 2025 EPP exercises. The surveyor did not receive any additional documentation from the licensee. The licensee's 2.28 Missing Resident policy dated June 1, 2025, indicated (licensee name) will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. The licensee's 4.01 Training, Exercises, and Testing (E-0036, E-0037) [sic] policy dated October 1, 2024, indicated annually (licensee name) will participate in a full-scale exercise that is community-based, or when a community-based exercise is not accessible, an individual, facility-based tabletop exercise. In addition, the facility will also conduct an additional annual exercise. Missing Person Policy: Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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	30439	A. BUILDING: _____ B. WING _____	07/08/2026

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MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

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0 680	Continued From page 12 Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. 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 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	0 775		

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0 775	Continued From page 13 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 July 06, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; 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	0 790		

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0 790	Continued From page 14 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 July 06, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 790		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 15 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 6th, 2026, for the specific violations related the	0 810		

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0 810	Continued From page 16 physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which	01440		

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01440	Continued From page 17 the individual begins working for the licensee for one of one employee (unlicensed personnel (ULP)-E). 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 July 6, 2026, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee records. In addition, at 9:19 a.m., LALD-A further stated one ULP worked alone on the night shift from 10:30 p.m. through 6:30 a.m. ULP-E was hired on October 17, 2025, to provide direct assisted living services to residents at the facility. ULP-E's employee record included a 30-Day Staff Performance review dated January 15, 2026, which indicated ULP-E worked as a ULP overnight and was completed by LALD-A. ULP-E's employee record lacked documentation of an appropriate licensed health professional or registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On July 7, 2026, at 9:01 a.m., LALD-A stated	01440		

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01440	Continued From page 18 LALD-A had the understanding that a supervisor had to complete the 30-day supervision requirement and was not aware it needed to be an RN or other appropriate licensed health professional. LALD-A further stated LALD-A had completed 30-day supervisions for ULPs and clinical nurse supervisor (CNS)-B had completed annual supervision for ULPs. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for and first performs the delegated tasks for residents and thereafter as needed based on performance [sic]. In addition, staff who provide delegated nursing or therapy tasks to resident at (licensee name) will be supervised by an RN or appropriate licensed health professional where services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks [sic]. Per Assisted: 144G.08 Definitions, Subp. 29. "Licensed Health professional" means a person, other than a RN or LPN, who provides assisted living services within the scope of practice of that person's health occupation license, registration, or certification as a regulated person who is licensed by an appropriate Minnesota state board or agency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01620	Continued From page 19	01620		
01620 SS=D	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 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	01620		

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01620	Continued From page 20 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 observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of two residents (R3) with a change of condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference July 6, 2026, at 9:08 a.m., clinical nurse supervisor (CNS)-B stated the registered nurse (RN) completed change of condition assessments for residents after a change in services or hospitalization. R3's diagnoses included diabetes, traumatic brain injury (TBI), and hearing loss.	01620		

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01620	Continued From page 21 R3's service plan dated November 1, 2025, indicated R3's services included medication administration, bathing reminders, socialization, and housekeeping. On July 7, 2026, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R3. R3's record included a 90-day Assessment dated June 2, 2026, which indicated R3 did not have a diagnosis of diabetes and did not receive services for blood glucose monitoring. R3's record included an Individualized Treatment or Therapy Management Plan dated July 1, 2026, which indicated R3 was prescribed a Libre (a device used to measure blood glucose levels in the blood continuously) and staff were to check R3's blood glucose levels four times per day. R3's record lacked a change of condition assessment after R3 was diagnosed with diabetes and began receiving blood glucose checks four times per day. On July 8, 2026, at 10:55 a.m., CNS-B stated R3 was diagnosed on July 1, 2026, with diabetes and began receiving blood glucose checks four times per day. CNS-B further stated CNS-B was on leave from the facility when R3 had a change of condition, and the other RN covering for CNS-B had not completed a change of condition assessment on R3, however, the RN had developed a blood glucose treatment plan for R3. CNS-B stated R3 should have had a change of condition assessment completed on July 1, 2026. The licensee's 6.01 Assessments, Reviews and	01620		

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01620	Continued From page 22 Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. The licensee's 6.19 Resident Change in Condition or Need policy dated August 1, 2021, indicated when changes in condition or need are identified, a RN will initiate a change in condition assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	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 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.	01640		

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01640	Continued From page 23 (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 one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 July 6, 2026, at 9:02 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included diabetes, traumatic brain injury (TBI), and hearing loss. R3's service plan dated November 1, 2025, indicated R3's services included medication administration, bathing reminders, socialization, and housekeeping. On July 7, 2026, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R3. R3's prescriber orders dated June 30, 2026,	01640		

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01640	Continued From page 24 included an order to monitor blood glucose levels. R3's record lacked evidence of the service plan being revised to include blood glucose checks four times per day. On July 8, 2026, at 10:49 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was on leave from the facility when R3 began receiving blood glucose checks four times per day and CNS-B was in the process of revising R3's service plan. CNS-B further stated the registered nurse (RN) who covered for CNS-B while on leave had not revised R3's service plan to include blood glucose checks. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans shall be revised, if needed, based on resident reassessments and monitoring. In addition, service plans and any revisions or updates shall be entered into the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Fergus Falls District Office
Minnesota Department of Health
2313 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Moorhead Manor
1710 13th Ave N
Moorhead, MN 56560
Clay County
Parcel:

Phone:

License Info

License: HFID 30439

Risk:
License:
Expires on:
CFPM: SUSAN CHRISTIANSON
CFPM #: FM3202; Exp: 12/23/2026

Inspection Info

Report Number: F1064261085
Inspection Type: Full - Single
Date: 7/8/2026 Time: 11:46:42 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 7
Delivery: Emailed

New Order: 2-400 Hygenic Practices
2-403.11A *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.0120A Discontinue allowing food employees to care for or handle animals that are allowed to be present in the establishment.
COMMENT: PIC'S PERSONAL PET (DOG) RAN THROUGH KITCHEN DURING INSPECTION. DISCONTINUE HAVING ANIMALS IN FOOD SERVICE AREAS.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: DISCARD ALL FOOD PRODUCTS THAT ARE NOT LABELED WITH PREPARATION DATE OR EXCEED 7 DAYS. MAJORITY OF LEFTOVER FOOD WAS ALSO BEING STORED IN COOL WHIP CONTAINERS AND SHOULD BE IN COMMERCIAL GRADE FOOD CONTAINER NOT A SINGLE USE FOOD CONTAINER.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT:
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-200 Equipment Design and Construction
4-202.11 *Priority Level: Priority 2 CFP#: 47*
MN Rule 4626.0515 Discontinue use of multi-use food-contact surfaces that are not smooth, free of breaks, open seams, cracks, chips, pits and other imperfections and that are not accessible for cleaning or inspection.
COMMENT: SURE FOOD TOOLS SPATULAS, PAN AND OTHER TOOLS ARE NOT CHIPPED OR MELTED, OR FLAKING NON STICK COATING. ORDERED TOOLS AND PAN TO BE DISPOSED OF WHILE ON SITE AND INSTRUCTED TO REPLACE WITH COMMERCIAL GRADE EQUIPMENT.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-300 Equipment Numbers and Capacities
4-303.11B *Priority Level: Priority 3 CFP#: 48*
MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.
COMMENT: SANITIZER BUCKET WAS NOT AVAILABLE FOR KITCHEN SURFACES DURING OPERATION.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C1 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.
COMMENT: DISH MACHINE WAS READING AT 0PPM.

REINSPECTED THE FOLLOWING DAY AND WAS AT 100PPM.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.116 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

COMMENT: ENSURE STAFF ARE USING TEST STRIPS TO TEST DISHWASHER DAILY.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: ENSURE DISHWASHER IN WORKING ORDER SANITIZER WAS AT ZERO PPM DURING INITIAL INSPECTION.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-500 Equipment Maintenance and Operation
4-502.13 *Priority Level: Priority 3 CFP#: 45*
MN Rule 4626.0830 Discontinue re-use of any single-service and single-use articles.
COMMENT: COOL WHIP CONTAINERS WERE BEING USED TO STORE LEFT OVERS. DISCONTINUE THIS PRACTICE.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT: HEAVY BUILD UP OF FOOD DEBRIS IN TOASTERS.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 5-500 Refuse and Recyclables
5-501.16C *Priority Level: Priority 3 CFP#: 54*
MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.
COMMENT: NO GARBAGE WAS AVAILABLE FOR HANDWASHING SINK, CLOSEST GARBAGE WAS UNDER COUNTER AT FOOD SERVING COUNTER.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

New Order: 6-400 Physical Facility Placement
6-403.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1500A Locate areas designated for employees to eat, drink and use tobacco so that food, equipment, linens, and single-service and single-use articles are protected from contamination.
COMMENT: ENSURE EMPLOYEE FOOD IS BEING STORED IN EMPLOYEE AREAS.
Comply By: 7/8/2026 Originally Issued On: 7/8/2026

Food & Beverage General Comment

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 F1064261085 from 7/8/2026

Kimberly Bredeson

SUSAN CHRISTIANSON
MANAGER

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Public Health Sanitarian 2
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Fergus Falls District Office
Minnesota Department of Health
2313 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Moorhead Manor
Moorhead
County/Group: Clay County

Inspection Info

Report Number: F1064261085
Inspection Type: Full
Date: 7/8/2026
Time: 11:46:42 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Ambient Air
Location: DINNING TABLE at 63 Degrees F.
Comment: TOLD PIC THAT MILK CANNOT BE LEFT OUT AT ROOM TEMP AND NEEDS TO BE UNDER MECHANICAL REFRIGERATION.
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: TOTINOS PIZZA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: PRODUCT SHOULD BE KEPT FROZEN ACCORDING TO PACKAGING. WAS TOLD THAT FOOD WAS FOR STAFF AND NOT RESIDENTS. DID PREVIOUSLY AS IF UPRIGHT COOLERS WERE FOR RESIDENTS ONLY AND WAS TOLD NO EMPLOYEES USE. INSTRUCTED TO REMOVE THE PIZZA PRODUCTS AND DISPOSE OR MOVE TO A STAFF FRIDGE.
Violation Issued?: Yes

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

Fergus Falls District Office
Minnesota Department of Health
2313 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Moorhead Manor
Moorhead
County/Group: Clay County

Inspection Info

Report Number: F1064261085
Inspection Type: Full
Date: 7/8/2026
Time: 11:46:42 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 0 PPM
Comment: LOG BOOK WAS ONSITE AND READ 100%. FOR DATE OF INSPECTION SHOWED STAFF NO CHLORINE WAS BEING DETECTED AND TO ENSURE DAILY TESTING OF UNIT AND NOT JUST WRITING 100 EVERYDAY. UNSURE HOW LONG UNIT WAS POSSIBLY READING AT 0PPM. INSTRUCTED TO USE PAPER SERVING PRODUCTS UNTIL REPAIRED.

ECOLAB WAS CALLED AND WAS REINSPECTED THE NEXT DAY AT 100PPM.
Violation Issued?: Yes

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30439016	**Date:** 7/6/2026
Facility Name: Moorhead Manor	
Facility Address: 1710 13th Ave. N. Moorhead MN 56560	

☒ **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. Emergency lighting shall be maintained in accordance with section 108 and shall be inspected and tested in accordance with sections [1031.10.1 and 1031.10.2]

   Comments: Upon testing the emergency light in the west hallway, it was found that the light was dim and appeared to not be working correctly. Licensed assisted living director (LALD)-A stated that these lights were inspected annually and not sure why they were not working properly.

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Monthly checks on the fire extinguishers by the staff was not being done. LALD-A stated she was not aware that the fire extinguishers needed to be inspected by staff monthly.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. There was no fire safety and evacuation plan provided.

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

3. *Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. There was no fire safety and evacuation plan provided.*

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide the fire safety and evacuation plan (FSEP) at the time of the survey.