Electronically Delivered

February 13, 2025

Licensee
Old Main Village
301 South 5th Street
Mankato, MN 56001

RE: Project Number(s) SL30663016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30663	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD MAIN VILLAGE	301 SOUTH 5TH STREET MANKATO, MN 56001

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0 000	Initial Comments 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: SL30663016 On December 9, 2024, through December 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 65 residents; 25 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 December 9, 2024, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of three employees (unlicensed personnel (ULP)-C) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of three employees (ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 4 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 TB facility risk assessment dated July 26, 2024, indicated the licensee was a low risk. ULP-C ULP-E was hired May 20, 2024, to provide direct care services. On December 10, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications to R1. ULP-C's employee record included a TB symptom screen from a former employer dated November 15, 2023. The record further included 2-step TST testing from the same prior employer. The first step placed November 15, 2023, and read November 17, 2023; the second step placed November 23, 2023, and read November 25, 2023. The TB symptom screen and two-step TST testing was completed greater than five months prior to hire. ULP-D ULP-D was hired August 18, 2022, to provide direct care services. ULP-D's employee record included a completed 2-step TST testing form. The first step was placed August 17, 2022, and read August 19,	0 660		

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0 660	Continued From page 5 2022. The second step was placed on October 4, 2022, and read on October 6, 2022. The second step had been placed 46 days after completion (reading) of the first step. On December 11, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-B reviewed ULP-C's TB symptom screen and TB testing from a previous employer upon hire and stated it did not meet the requirements. CNS-B reviewed ULP-D's 2-step TST results completed upon hire and stated the second step had not been initiated within 21 days of the first step as required. The licensee's 8.16 Tuberculosis Screening policy reviewed May 15, 2024, indicated: Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and commented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative	0 660		

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0 660	Continued From page 6 IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During facility tour on December 11, 2024, from 10:21 a.m. through 11:45 a.m., with licensed assisted living director (LALD)-A and director of maintenance (DM)-F, the surveyor observed door wedges holding fire rated doors open in the following locations: Second floor laundry room located by resident room 204, 90-minute fire rated door. Second floor doors leading into dining area, 20-minute fire rated doors. Third floor laundry room located by resident room 304, 90-minute fire rated door. Third floor laundry room located by resident room 328, 90-minute fire rated door. Basement door leading into pool area, 20-minute	0 780		

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0 780	Continued From page 8 fire rated door. First floor activity room door, 90-minute fire rated door. Fire-resistant rated doors must automatically close and latch to prevent the spread of smoke and fire to adjoining building areas. LALD-A and DM-F removed the door wedges during the tour and stated they understood the requirement. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 9 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). 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-D was hired to provide direct care services	01370		

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01370	Continued From page 10 on August 18, 2022. ULP-D's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided. On December 11, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-A reviewed ULP-D's employee file and stated it did not include evidence the above training had been completed. The licensee's 5.02 Competency Training Evaluations policy reviewed August 10, 2023, indicated: 5. Training and competency evaluations of ULPs will include: a) Documentation requirements for all services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse,	01380		

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01380	Continued From page 11 and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). 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-D was hired to provide direct care services on August 18, 2022. ULP-D's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - observing, reporting, and documenting resident status; and - recognizing physical, emotional, cognitive, and developmental needs of the client. On December 11, 2024, at 11:18 a.m. clinical	01380		

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01380	Continued From page 12 nurse supervisor (CNS)-A reviewed ULP-D's employee file and stated it did not include evidence the above trainings had been completed. The licensee's 5.02 Competency Training Evaluations policy reviewed August 10, 2023, indicated: 6. In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status d. Recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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	30663	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD MAIN VILLAGE	301 SOUTH 5TH STREET MANKATO, MN 56001

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01500	Continued From page 13 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 14 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D and licensed practical nurse (LPN)-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 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-D was hired to provide direct care services on August 18, 2022. LPN-E was hired to provide direct care services on August 10, 2015. ULP-D and LPN-E's employee records lacked evidence the employee had successfully completed annual training as required, to include the following: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On December 11, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-A reviewed ULP-D and	01500		

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01500	Continued From page 15 LPN-E's employee files and stated they did not include evidence the above annual training had been completed. The licensee's 5.06 Annual Required Staff Training policy reviewed February 12, 2024, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1).	01710		

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01710	Continued From page 16 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 December 9, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included chronic obstructive pulmonary disease (COPD). R1's Service Plan dated April 26, 2024, indicated services included medication administration. R1's medication administration record (MAR) dated December 2024, included an order of ipratropium/albuterol solution (Duoneb), inhale one ampule via nebulizer three times daily for COPD. R1's Medication Assessment and Management Plan dated November 25, 2024, indicated R1 was unable to safely self-administer medications; staff manages and administers medications. R1's comprehensive nursing assessment dated November 25, 2024, indicated R1 was unable to self-administer her ipratropium-albuterol inhalation solution.	01710		

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01710	Continued From page 17 On December 10, 2024, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's morning medications including the ipratropium-albuterol inhalation solution. ULP-C opened the ampule containing the solution and poured into the nebulizer receptacle for the medication. ULP-C gave the breathing apparatus attachment to R1, then turned on the nebulizer machine once R1 had placed the attachment in her mouth. ULP-C stated she would return to R1's room in a few minutes to rinse out the medication receptacle once the medication had been dispensed. ULP-C then exited R1's apartment prior to the medication being completely administered to the resident. On December 10, 2024, at 11:58 a.m. clinical nurse supervisor (CNS)-B stated feeling comfortable with R1 administering her own nebulizer medication once it had been set up by the staff. CNS-B reviewed R1's current comprehensive assessment and medication assessment and stated this was not reflected in the assessments. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy reviewed February 12, 2024, indicated: The Assisted Living Facility will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

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01730	Continued From page 19 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to revise an individualized medication management plan for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 9, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included type II diabetes and atrial fibrillation. R2's Service Plan and Agreement dated July 1, 2024, indicated services included medication administration. R2's Medication Assessment and Management Plan dated June 26, 2024, indicated R2's prescribed medications were stored in a locked cabinet in the resident's room.	01730		

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01730	Continued From page 20 On December 10, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-C set up and administer R2's morning medications. The medications were stored in a locked medication cart. On December 10, 2024, at 2:35 p.m., CNS-B reviewed R2's medication management plan and stated the storage of medications was inaccurate and should have been updated. The licensee's 7.03 Medication Management Individualized Plan reviewed February 12, 2024, indicated: 1. The assisted living facility will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 21 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1). 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	01940		

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01940	Continued From page 22 situation has occurred only occasionally). The findings include: During the entrance conference on December 9, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including oxygen therapy. R1's diagnoses included chronic obstructive pulmonary disease (COPD). R1's Service Plan and Agreement dated April 26, 2024, indicated services including oxygen assistance. R1's medication administration record (MAR) dated December 2024, included an order for oxygen. The order indicated to check portable oxygen tank. Dial should be set to "2" liters during the day while resident is using in her apartment and when ambulating outside of her apartment. At bedtime, concentrator in bedroom should be set to "1" liter. Help resident with nasal cannula. The MAR also had an order for oxygen saturation and indicated: Check oxygen saturation as needed. Call nurse if oxygen saturation is below 88 and resident does not respond to supplemental oxygen and rest. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On December 10, 2024, at 11:58 a.m. CNS-B stated the ULPs do not check oxygen saturation levels for R1 and further stated R1's treatment	01940		

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01940	Continued From page 23 plan did not include direction to staff of when to notify a nurse when problems arose with the resident's oxygen therapy. The licensee's 7.05 Treatment & Therapy Management Plan policy reviewed February 12, 2024, indicated: 1. The assisted living facility will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Dept. of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza
Mankato, MN

Type: Full
Date: *12/09/24*
Time: 11:39:51
Report: 1028251009

Food and Beverage Establishment Inspection Report

Location:
Old Main Village
301 South 5th Street
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0039030
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073884200
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-200B Food Characteristics:Receiving: temperature, condition
3-202.14A ***** Priority 1 *****
MN Rule 4626.0177A Discard unpasteurized egg products.
Discard all unpasteurized eggs. Begin only using and serving pasteurized eggs.
Comply By: 12/09/24

5-200C Plumbing: Maintenance, fixture location
5-205.11AB ***** Priority 2 *****
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
Relocate items in front of the front service area handwashing sink such that employees can easily access the sink at all times.
Comply By: 12/09/24

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
A Certified Food Protection Manager must be employed as soon as possible. Ensure that whoever takes the CFPM course also sends in their certificate to the State in order to receive State CFPM Licensure.
Comply By: 12/09/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

The large containers of flour and sugar located in the kitchen area must be labeled.

Comply By: 12/09/24

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

All clean utensils must be inverted such that the handle is facing up and the food contact surface is facing down.

Comply By: 12/09/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -5 Degrees Fahrenheit - Location: Freezer - Ambient
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	3

This Inspection was conducted in conjunction with HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028251009 of 12/09/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Bonnie Hough
Executive Director

Signed: Ryan Miller
Ryan Miller
Environmental Health Specialist
MDH - Mankato
507-995-7672
Ryan.Miller@state.mn.us