



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 10, 2026

Licensee
Traditions of Waterville
117 Paquin Street East
Waterville, MN 56096

RE: Project Number(s) SL30618016

Dear Licensee:

On March 25, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 22, 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,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

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

KKM



Protecting, Maintaining and Improving the Health of All Minnesotans

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February 12, 2026

Licensee
Traditions of Waterville
117 Paquin Street East
Waterville, MN 56096

RE: Project Number(s) SL30618016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

pursuant to this survey:

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

St - 0 - 1690 - 144g.71 Subdivision 1 - Medication Management Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00.** 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:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096		
(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: SL30618016-0 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 46 residents; 43 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issued on January 20, 2026, at a level 3/Widespread. The licensee took immediate action; however, the scope and level remains at I. 1690: An immediate correction order was issued on January 22, 2026, at a level 3/Widespread. The licensee took immediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 20, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480			

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0 480	Continued From page 3 Reports were provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during AM cares by one of two unlicensed personnel (ULP-F). 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	0 510			

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0 510	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's Individualized Service Plan signed May 8, 2025, indicated the resident received services to include dressing, grooming, bathing, toileting, escorts to and from meals and activities, medication administration, housekeeping and laundry. On January 21, 2026, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-F providing morning cares for R6; ULP-J in training was also present in R6's apartment during the observation. ULP-F donned gloves and assisted R6 with sitting up on the edge of the bed. ULP-F then obtained R6's compression stockings and applied them to her lower legs while ULP-J obtained two outfits from R6's closet for the resident to choose from. After applying R6's compression stockings, ULP-F then provided stand-by assistance while R6 ambulated to the bathroom utilizing her walker. R6 was able to get herself to the toilet, lower her pants/brief and sit on the toilet independently. Once R6 was seated on the toilet, ULP-F then removed R6's pajama pants and incontinence brief, then applied a clean brief, pants and shoes. ULP-F then removed R6's pajama top, applied deodorant to the resident's armpits, then assisted R6 with putting on a clean top. ULP-F then asked R6 if she would like her to set-up her toothbrush and toothpaste; R6 stated "yes." ULP-F then obtained R6's toothbrush, applied toothpaste to the toothbrush and set it on the resident's vanity near the sink. ULP-F provided stand-by assistance to R6 when the resident stood up and pulled up her pants prior to the resident brushing her teeth. ULP-F then	0 510			

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0 510	Continued From page 5 removed the trash bag in the bathroom and placed a new bag in the wastebasket. ULP-F then removed and disposed of her gloves and brought the trash bag and R6's soiled pajamas out to R6's closet area. ULP-F then made R6's bed and ensured the resident's bed and chair alarms were turned on. When R6 finished her oral cares, she ambulated out of the bathroom and into her living room area independently using her walker. R6 then asked ULP-F for her wheelchair. ULP-F obtained R6's wheelchair and assisted R6 with sitting then wheeled R6 out to the dining room for breakfast. ULP-F then entered the nursing office and logged into the computer to document R6's cares at 8:02 a.m. At this time, the surveyor asked ULP-F at what point she would perform hand hygiene. ULP-F stated she should have washed hands after assisting the resident with cares, removing gloves, and prior to going onto the next task and forgot to do this. On January 22, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated she would expect hand hygiene be completed prior to assisting a resident, upon glove removal, changing gloves when working with something soiled, then cleanse hands and don new gloves. CNS-B further stated hand hygiene should be completed prior to exiting the resident's room. The licensee's Hand Hygiene policy dated August 1, 2021, indicated: 1. When Hands Should be Washed. Hand washing shall be performed between client (resident) cares and whenever direct physical contact with a client (resident) takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a	0 510			

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0 510	Continued From page 6 client (resident); b. If moving from a contaminated body site to a clean body site during client (resident) care; c. After contact with environmental surfaces or equipment in the immediate vicinity of the client (resident); d. After removing gloves or gowns; e. Before eating and after using a restroom No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 establish and	0 660			

Minnesota Department of Health

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0 660	Continued From page 7 maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) within the required timeframe for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB risk assessment dated November 17, 2025, indicated the licensee was a low risk. On January 21, 2026, at 8:53 a.m., the surveyor observed ULP-G administering medications to R5. ULP-G's employee record indicated a start date of July 7, 2025. ULP-G's employee's record contained a Baseline TB Screening Tool for Health Care Workers form dated July 7, 2025. The form indicated ULP-G had a first-step TST administered on July 7, 2025, at 11:30 a.m., and read on July 9, 2025, at 9:00 a.m. The form further indicated ULP-G had a second-step TST administered on July 29, 2025, at 9:00 a.m., and read on July 31, 2025, at 8:45 a.m.	0 660			

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0 660	Continued From page 8 ULP-G's TST results were read less than 48 hours after each step was placed. On January 23, 2026, at 2:00 p.m., registered nurse (RN)-C reviewed ULP-G's first and second step TSTs and stated they had not been read between 48 and 72 hours after being placed as required. The licensee's TB Prevention and Control policy dated Mary 27, 2022, indicated: Clarification of the two-step TST: The first step of the two-step TST is to have an infection of tuberculin purified protein derivative (PPD) into the surface of the forearm, wait for 48 to 72 hours, and have the skin test reaction read. The second step of the two-step TST is to repeat this test seven to 21 days after the first TST is read. This two-step approach is used to reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced	0 690			

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0 690	Continued From page 9 by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry for two of three residents (R3, 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 situation has occurred only occasionally). The findings include: R3 R3's Initial Unified Assessment and 90 Day Unified Assessment were not dated or authenticated with the title of the person completing the assessment. On January 22, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B reviewed R3's initial and 90 day assessments and stated being able to see in the electronic record when the assessments had been "locked;" although these two had not been dated or authenticated. CNS-B further stated if the button to submit signature is not pushed prior to locking the assessment the date and authenticated signature will not show up on the actual assessment. R1 R1's record contained two Return From Hospital Unified Assessments that were not dated or authenticated with the title of the person	0 690			

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0 690	Continued From page 10 completing the assessment. On January 23, 2026, at 11:11 a.m., registered nurse (RN)-C reviewed R1's assessments and stated there were two return from hospital assessments that had not been authenticated with a date and signature; these were locked on December 3, 2025, and January 19, 2026. The licensee's Resident Records policy dated August 1, 2021, indicated: 1. Record entries will be legible, permanently recorded, dated, and signed by the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
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	0 775			

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0 775	Continued From page 11 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 12 Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for one of 49 employees (cook (C)-D). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on January 20, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: C-D was hired on July 12, 2023, to provide culinary services for the licensee's residents. On January 20, 2026, at approximately 2:00 p.m., licensed assisted living director (LALD)-A provided the licensee's NETStudy 2.0 employee roster for health facility identification number (HFID) 30618 dated January 20, 2026, at 11:25 a.m., at the surveyor's request. The licensee's NETStudy 2.0 roster did not include C-D. On January 20, 2026, at 2:37 p.m., LALD-A stated C-D was still employed by the licensee on a casual basis and did not require supervision. LALD-A stated C-D had put in her notice of	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

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01290	Continued From page 13 resignation, at which time LALD-A removed C-D from the licensee's NETStudy employee roster. LALD-A stated she failed to resubmit C-D's background study to the roster when C-D decided to stay on as a casual employee. The licensee's Background Checks policy dated May 27, 2022, indicated: All employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 20, 2026, the facility implemented corrective actions to address this issue. The scope and severity remains at I.	01290			
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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01500	Continued From page 14 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 15 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F). 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-F was hired on July 5, 2023, to provide direct care services to residents of the facility. On January 21, 2026, at 7:43 a.m., the surveyor observed ULP-F assisting R6 with morning cares. ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 23, 2026, at 2:35 p.m., licensed assisted living director (LALD)-A stated being	01500			

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01500	Continued From page 16 unable to locate evidence ULP-F had completed the above trainings. The licensee's Assisted Living Annual Training policy dated May 27, 2022, indicated: 1. All assisted living employees will complete annual education on the following topics: b. Assisted living bill of rights h. Principles of person-centered planning and service delivery applies to direct support services provided by staff No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to	01540			

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01540	Continued From page 17 mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) completed the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 had an Assisted Living with Dementia Care license dated August 1, 2025. ULP-G was hired on July 7, 2025, to provide direct care services to residents of the facility. On January 21, 2026, at 8:53 a.m., the surveyor observed ULP-G administering medications to R5 in the secure memory care unit. ULP-G's employee file did not include the required eight hours of dementia training within 80 hours of employment as required. On January 23, 2026, at 2:35 p.m., licensed	01540			

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01540	Continued From page 18 assisted living director (LALD)-A reviewed ULP-G's employee file and stated ULP-G had 7.5 hours of dementia training and not the 8 hours as required. LALD-A further stated ULP-G had worked greater than 80 hours for the licensee. The licensee's Assisted Living or Assisted Living With Memory Care Dementia Training policy dated August 1, 2021 indicated: 3-C. Orientation: Assisted Living with Dementia Care licensed settings ii. Direct-care employees will 1. complete a minimum of eight hours of initial training on dementia care topics 2. initial training will be completed within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be	01620			

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01620	Continued From page 19 conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14	01620			

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01620	Continued From page 20 days of admission for two of two new residents (R3, R1) and failed to complete a change of condition assessment timely for one of three residents (R2) upon return from hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted on January 22, 2025, with diagnoses including dementia, rheumatoid arthritis, lumbar spinal stenosis, obstructive sleep apnea, malignant neoplasm of the left lung, and acute respiratory failure. R3's Individualized Service Plan signed January 22, 2025, indicated R3 received services which included dressing, grooming, bathing, behavior monitoring, escorts to and from meals and activities, medication administration, housekeeping and laundry. R3's record included an admission assessment completed January 22, 2025, and a 14-day assessment completed February 6, 2025. 15 days had passed between the admission assessment/start of services, and the 14-day assessment (one day late). On January 22, 2026, at 9:43 a.m. clinical nurse	01620			

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01620	Continued From page 21 supervisor (CNS)-B reviewed R3's assessments and stated the 14-day assessment had been completed late. R1 R1 was admitted on April 22, 2025, with diagnoses including type II diabetes mellitus, acute kidney failure, epilepsy, cerebrovascular disease, and retention of urine. R1's Individualized Service Plan signed April 22, 2025, indicated R1 received services which included bathing, dressing, grooming, toileting, transfers housekeeping, laundry, medication administration, escorts to and from meals and activities, and catheter care. R1's record included an admission assessment dated April 22, 2025, and a 14-day assessment dated May 7, 2025. 15 days had passed between the admission assessment/start of services, and the 14-day assessment (one day late). On January 23, 2026, at 11:11 a.m., RN-C reviewed R1's assessments and stated the 14-day assessment had been completed late. R2 During the entrance conference on January 20, 2026, at 9:58 a.m., CNS-B stated if a resident returned from the hospital during off hours, an RN would come into the facility to complete the assessment. R2 was admitted on April 8, 2022, with diagnoses including dementia, controlled diabetes mellitus with diabetic cataract, chronic kidney disease, bilateral lower edema, hypertension, and urinary retention.	01620			

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01620	Continued From page 22 R2's Individualized Service Plan signed December 18, 2026, indicated R2 received services which included dressing, grooming, bathing, repositioning, toileting, medication administration, escorts and from meals and activities, behavior monitoring, assist of two with Hoyer transfers, oxygen therapy, catheter care, housekeeping and laundry. R2's progress note dated November 11, 2025, at 13:26 (1:36 p.m.), indicating the following: Received call at 06:29 (6:29 a.m.) that this resident was experiencing SOB (shortness of breath). Respiration around 40, elevated bp (blood pressure 142/111), oxygen sats (saturation) at 75% on 02 (oxygen) (staff did not specify if 02 was set at 1 L (liter) or 2 L). Staff state resident appeared very sweaty. Staff advised to call EMS (emergency medical services) and notify family. Staff called back to report resident was transferred to [hospital name]. R2's progress note dated November 20, 2025, at 14:43 (2:43 p.m.), indicated the resident returned from the hospital on 11/19/2025 (November 19, 2025). R2's Return from Hospital Unified Assessment was dated November 24, 2025; five days after R2 returned from the hospitalization. On January 23, 2026, at 10:56 a.m., RN-C stated R2's return from hospital assessment dated November 25, 2025, had been completed late. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated May 27, 2022, indicated: 1. A RN will complete the following	01620			

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01620	Continued From page 23 comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required. a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition 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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(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
01640	Continued From page 24 (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 a written service plan was revised to reflect the current services provided for one of three 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: R2 was admitted on April 8, 2022, with diagnoses including dementia, controlled diabetes mellitus with diabetic cataract, chronic kidney disease, bilateral lower edema, hypertension, and urinary retention. R2's ADL Flowsheet dated January 2026, included: Dressing Devices: Compression Wrap. Staff to apply in the morning and remove in the evening. On January 23, 2026, at 11:08 a.m., ULP-I stated stated R2 has Velcro compression wraps that they apply to her lower legs in the morning and remove in the evening. ULP-I and the surveyor observed R2 seated in a Broda wheelchair in the dining room; R3 had black Velcro compression wraps on her lower legs.	01640			

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01640	Continued From page 25 R2's Individualized Service Plan signed December 18, 2026, indicated R2 received services which included dressing, grooming, bathing, repositioning, toileting, medication administration, escorts and from meals and activities, behavior monitoring, assist of two with Hoyer transfers, oxygen therapy, catheter care, housekeeping and laundry. R2's service plan did not include the compression wraps. On January 23, 2026, at 11:11 a.m., registered nurse (RN)-C stated R3's compression wraps were not included in the service plan and that she had "missed it". The licensee's Contents of Service Plans policy dated August 1, 2021, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640			
01690 SS=I	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and	01690			

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01690	Continued From page 26 procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow the manufacturer's instructions and licensee's policy regarding destruction of a schedule II-controlled substance/medication for one of one resident (R3) when the licensee stored used fentanyl transdermal patches in a screw top container for disposal at a future date. This resulted in an immediate correction order on January 22, 2026.	01690			

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01690	Continued From page 27 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's diagnoses included dementia, rheumatoid arthritis, and itching. R3's Individualized Service Plan dated January 22, 2025, indicated R3's services included medication administration. R3's provider orders dated December 8, 2025, included: fentanyl 25 mcg/hr (micrograms per hour) transdermal patch. Apply and change one patch every 72 hours. On January 21, 2026, at 12:23 p.m., registered nurse (RN)-C stated when R3's fentanyl patch was removed, staff folded it and put it into a sharps container. RN-C further stated the licensee did not require staff to document destruction of the fentanyl patch. On January 21, 2026, at 12:49 p.m., the surveyor accompanied RN-C into the staff office on the memory care unit. RN-C opened a locked lower cupboard and removed a round red container with a slit in the top. RN-C stated staff would fold the fentanyl patch in half and put it into the container through the slit. The surveyor asked if the top of the container was locked. RN-C demonstrated that the cover could easily be	01690			

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01690	Continued From page 28 unscrewed and removed, thus anything in the container could be obtained. The container was approximately two thirds full of used fentanyl patches and also fentanyl patches that had been disposed of inside a glove prior to being put into the red container. RN-C stated this was not a secure method of disposal for narcotic medication. On January 22, 2026, at 12:09 p.m., clinical nurse supervisor (CNS)-B, being in her current position since October 2025, stated no fentanyl patches had been destroyed while she was in her position. CNS-B further stated the licensee would wait until their MedSafe (medication disposal system) was full before putting the fentanyl patches into it for permanent destruction. CNS-B further stated this was too long to wait. The fentanyl manufacturer's instructions revised March 2021, indicated: - Failure to properly dispose of Duragesic (fentanyl transdermal patch) has resulted in accidental exposures and deaths. - Instruct patient to dispose of used patches immediately upon removal by folding the adhesive side of the patch to itself, then flushing down the toilet. - Instruct patient to remove unused patches from their pouches, remove the release liners, fold the patches so that the adhesive side of the patch adheres to itself, and to immediately flush the patches down the toilet. - Instruct patient to dispose of any patches remaining from prescription as soon as they are no longer needed. The licensee's Controlled Substances/Schedule II Drugs policy dated August 1, 2021, indicated: The licensee would take all reasonable	01690			

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01690	Continued From page 29 precautions to eliminate the theft, diversion, or misuse of controlled substances and would comply with requirements regarding the safe storage and disposal of these drugs. The policy also stated: - Unused portions of a controlled substance that were permanently discontinued must be disposed of by the licensed health professional and one other witness designated by the assisted living agency. - The RN and the witness shall dispose of controlled medications by flushing them into the sewer system until such time as state and federal agencies specify a legally acceptable alternative method for disposal. - For any controlled substance/Schedule II medication that was destroyed, the RN would complete the appropriate form or incorporate in the resident's EMR (electronic medical record) and would incorporate it into the resident's file. The licensee's Administration of Transdermal Patch policy last reviewed March 1, 2023, gave instructions for transdermal patches that were not controlled substances. The policy instructed to follow the agency policy for the disposal of a transdermal patch that contained a controlled substance. That policy was not available for review. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 23, 2026, the facility implemented corrective actions to address this issue. The scope and severity remains at I.	01690			

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01760	Continued From page 30	01760			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication procedures were followed related to documentation of removal of a Fentanyl patch either by staff or when the patch had fallen off or been pulled off (by the resident) for one of one resident (R3). In addition, the licensee failed to remove an expired medication for one of one resident (R3) with ear drops observed during medication administration. 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).	01760			

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01760	Continued From page 31 The findings include: R3 R3's diagnoses included dementia, rheumatoid arthritis, and itching. R3's Individualized Service Plan dated January 22, 2025, indicated R3's services included medication administration. R3's provider orders dated December 8, 2025, included: Fentanyl 25 mcg/hr (micrograms per hour) transdermal patch. Apply and change one patch every 72 hours. On January 21, 2026, at 11:18 a.m., the surveyor observed R3 seated in a recliner in her apartment with her feet elevated and a blanket over her lap. R3 stated she was having pain "all over". R3 stated she hadn't told staff about it, but it was ok if the surveyor notified staff. At 11:20 a.m., the surveyor notified unlicensed personnel (ULP)-G of R3's complaints of pain. ULP-G stated R3 had a PRN (as needed) Tylenol order, although would not be able to give at this time as R3 had just received her scheduled dose of Tylenol. ULP-G further stated R3 had a Fentanyl patch for pain ordered every three days; although it falls off frequently or gets caught up in her clothes. The surveyor asked ULP-G if R3 had a Fentanyl patch on at this time and she stated, she didn't think so, but she wasn't sure. On January 21, 2026, at 12:23 p.m., registered nurse (RN)-C stated R3 does remove her Fentanyl patch at times due to complaints of itching. RN-C stated the Fentanyl patch is replaced every three days; staff do not track if the patch has fallen off and do not chart that the old patch was removed. RN-C further stated that	01760			

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01760	Continued From page 32 sometimes on the weekend R3 has pulled the patch off. When RN-C had come in on a Monday after this happened, R3 was extremely tired and RN-C had found the Fentanyl patch was not on, and and R3 was "withdrawing". On January 21, 2026, at 12:49 p.m., RN-C and the surveyor went into R3's apartment to check for placement of R3's Fentanyl patch. RN-C checked R3's back, shoulders, and upper arms; the patch was not present. On January 22, 2026, at 8:33 a.m., clinical nurse supervisor (CNS)-B stated she spoke with ULP-H who had administered R3's Fentanyl patch the morning of January 21, 2026. ULP-H had stated to CNS-B that she had returned to the facility that evening (January 21, 2026) to visit a family member. The ULPs on duty had indicated to ULP-H that they had removed R3's Fentanyl patch because R3 was complaining of extreme itching from it. ULP-H stated she advised the ULPs to write a note to CNS-B informing her about it and to put the note under CNS-B's office door. CNS-B stated this did not happen, nor was it documented in R3's record. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated: 1. Staff will document each task immediately after that task has been performed. R5 R5's diagnoses included cerumen impaction. R5's Individualized Service Plan dated January 2, 2026, indicated R5's services included medication administration.	01760			

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01760	Continued From page 33 R5's provider visit note dated November 10, 2025, included the following order: GNP earwax removal drops 6.5% otic solution. Instill 3 drops in each ear twice weekly. On January 21, 2026, at 8:53 a.m., the surveyor observed ULP-G setting up R5's AM medications including the GNP earwax removal drops. The manufacturer's expiration date on the box indicated: November 3, 2025. The surveyor stopped ULP-G prior to administering R5's medications and pointed out that the ear drops had expired. ULP-G searched for a new bottle of the ear drops and found none available. ULP-G then stated she ordered a new bottle and placed the ear drops aside for destruction. On January 22, 2026, at 9:43 a.m., CNS-B stated ULP-K performs periodic audits on the medication carts. ULP-K had conducted an audit the day before and had removed the ear drops from the medication cart. CNS-B was unsure how the ear drops ended up back in the cart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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 must also develop and maintain a current	01940			

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01940	Continued From page 34 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 observation, 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 three 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	01940			

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01940	Continued From page 35 situation has occurred only occasionally). The findings include: R2 was admitted on April 8, 2022, with diagnoses including dementia, controlled diabetes mellitus with diabetic cataract, chronic kidney disease, bilateral lower edema, hypertension, and urinary retention. R2's ADL Flowsheet dated January 2026, included: Dressing Devices: Compression Wrap. Staff to apply in the morning and remove in the evening. R2's Individualized Service Plan signed December 18, 2026, indicated R2 received services which included dressing, grooming, bathing, repositioning, toileting, medication administration, escorts and from meals and activities, behavior monitoring, assist of two with Hoyer transfers, oxygen therapy, catheter care, housekeeping and laundry. R2's service plan did not include the compression wraps. On January 23, 2026, at 11:08 a.m., ULP-I stated stated R2 has Velcro compression wraps that they apply to her lower legs in the morning and remove in the evening. ULP-I and the surveyor observed R2 seated in a Broda wheelchair in the dining room; R3 had black Velcro compression wraps on her lower legs. ULP-I reviewed R3's administration record and stated it did not give direction to staff on when to contact the RN when issues arise with the compression wraps. On January 23, 2026, at 11:11 a.m., registered nurse (RN)-C stated R3's compression wraps were not included in the service plan and that she had "missed it". RN-C further stated R3's record	01940			

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01940	Continued From page 36 did not include direction to staff on when to contact the RN when issues arise with the compression wraps. The licensee's undated, form titled Individualized Treatment and Therapy Management Plan indicated: Our home care staff will provide ordered or prescribed treatment and therapy services. Your treatment and therapy management plan will be reviewed periodically and modified as needed. We have included a description of the treatment and therapy management services that will be provided by by our facility staff: (1) the type of services that will be provided will be recorded in your TAR (treatment administration record) (2) documentation of specific resident instructions relating to the treatments or therapy administration will be recorded in your TAR. (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel in your TAR (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 al 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 will be current with specific resident instructions and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940			

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01940	Continued From page 37	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-G) demonstrated competency in Velcro compression wraps, oxygen therapy, and continuous positive airway pressure (CPAP) machine to a registered nurse (RN). 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	01950			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 38 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 January 20, 2026, at 9:58 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services including assistance with compression wraps, oxygen therapy, and CPAP machines. ULP-G was hired to provide direct care services to the licensee's residents on July 7, 2025. ULP-G's employee record did not include competencies for Velcro compression wraps, oxygen therapy, or CPAP machine. On January 23, 2026, at 2:00 p.m., registered nurse (RN)-C stated all ULPs should be trained and competency tested for delegated treatments and therapies including Velcro compression wraps, oxygen, and CPAP machine. RN-C further stated they currently have residents in the facility that require assistance with the above treatments. On January 23, 2026, at 2:35 p.m., licensed assisted living director (LALD)-A stated she was unable to locate documented evidence of the above trainings/competencies for ULP-G. The licensee's Training Documentation policy dated August 1, 2021, indicated: Staff training will be documented completely and correctly. 1. A record of staff training and competency will	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 39 be maintained. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided subject to acceptable health care and medical, or nursing standards related to training records for one of two employees (unlicensed personnel (ULP)-G). 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-G was hired to provide direct care services to the licensee's residents on July 7, 2025.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096		
(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
02310	Continued From page 40 On January 21, 2026, at 8:53 a.m., the surveyor observed ULP-G administering medication to R5. ULP-G's employee record included competency training forms signed by ULP-G and a registered nurse (RN) for medication administration routes and other delegated tasks. The forms appeared to have been altered as the line to fill in the employee's name and date of training had breaks it as if it was whited out. The employee signature and date lines of the forms also had breaks in them as if whited out. On January 22, 2026, at approximately 3:56 p.m., licensed assisted living director (LALD)-A stated the former RN who completed ULP-G's competency trainings was a new nurse. LALD-A stated the RN couldn't locate the blank competency forms to complete for ULP-G. The RN then copied another employee's completed competency forms, then whited out the employee's name and dates on the forms, recopied, then utilized the altered forms for ULP-G. The eBook titled Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W.R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). included a table (Table 26.1) titled, Legal Guidelines for Documentation. The table included the following verbiage: Guidelines for Electronic and Written Documentation - If your agency uses paper documentation, only use a black pen with legible handwriting. Do not erase, apply correction fluid, or scratch out errors made while documenting in a paper record. Rational - Charting becomes illegible; it appears as if you	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096		
(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
02310	Continued From page 41 were attempting to hide information or deface record. Correct Action - Draw single line through error, write word error above it, and sign your name or initials. Then document note correctly. Check agency policy. The licensee's Personnel Records policy dated May 27, 2022, indicated: Personnel records will be kept up-to-date, well organized and confidential and will comply with the assisted living law and other relevant laws. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP-F) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 42 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: R2 was admitted on April 8, 2022, with diagnoses including dementia, controlled diabetes mellitus with diabetic cataract, chronic kidney disease, bilateral lower edema, hypertension, and urinary retention. R2 was admitted to hospice services on December 14, 2025, with a diagnosis of chronic obstructive pulmonary disease (COPD). R2's Individualized Service Plan signed December 18, 2026, indicated R2 received services which included dressing, grooming, bathing, repositioning, toileting, medication administration, escorts and from meals and activities, behavior monitoring, assist of two with Hoyer transfers, oxygen therapy, catheter care, housekeeping and laundry. R2's After Visit Summary dated December 3, 2025, included the following order: ipratropium-albuterol 0.5-2.5 mg (milligrams)/3 ml (milliliter) nebulizer solution. Inhale 3 ml by nebulization four times a day. R2's Significant Change Unified Assessment dated December 16, 2025, indicated: Resident is deemed unable to safely administer medications. On January 21, 2026, at approximately 8:59 a.m., the surveyor observed ULP-F removing a nebulizer medication vial from the medication	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF WATERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 117 PAQUIN STREET EAST WATERVILLE, MN 56096			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 43 cart. ULP-F stated to trainee ULP-J that she was going to administer R2's nebulizer medication. At 9:07 a.m., the surveyor entered R2's room and observed R2 lying in bed on her back with the head of bed raised approximately 30 degrees. R2 had on a nebulizer mask over her mouth with the nebulizer machine running and medication still observed in the reservoir attachment. There were no staff in the room with R2 while the nebulizer was running. On January 21, 2026, at 11:59 a.m., ULP-F stated staff didn't have to remain with R2 while her medication was being administered via nebulization, and further stated the nurses were ok with this. ULP-F stated R2 will sometimes take the mask off while the medication is being administered. ULP-F further stated she checks on R2 after about 10 minutes once the nebulization has been started to make sure R2 still had the mask on. On January 21, 2026, at 12:23 p.m., registered nurse (RN)-C stated R2 would not be able to self-administer medication via nebulizer independently once set-up by staff, as R2 would probably remove the mask before all medication was administered. RN-C stated staff are trained to remain with the resident during a nebulizer treatment unless the resident has been assessed to administer independently and also with a provider order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

TRADITIONS OF WATERVILLE
117 Paquin Street East
Waterville, MN 56096
Le Sueur County
Parcel:

Phone:

License Info

License: HFID 30618

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

Inspection Info

Report Number: F1034261017
Inspection Type: Follow-up - Single
Date: 1/26/2026 Time: 11:15:24 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

Previous Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B *Priority Level: Priority 3 CFP#: 43*

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

COMMENT: The dispensing utensil for the sugar does not have a handle. The dispensing utensil must have a handle so that the food contact surface is not contaminated by hands.

Comply By: Complied On Site Originally Issued On: 1/20/2026

Previous Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: Need an irreversible thermometer for the dishwasher. It should be run through the dishwasher at least 3 times per week. The temperature must reach at least 160 degrees F.

1/26/26 PIC stated that thermometer is on order from vendor.

Comply By: 1/25/2026 Originally Issued On: 1/20/2026

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 Mankato District Office inspection report number F1034261017 from 1/26/2026

Establishment Representative

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Page: 1

Establishment Info

TRADITIONS OF WATERVILLE
Waterville
County/Group: Le Sueur County

Inspection Info

Report Number: F1034261017
Inspection Type: Follow-up
Date: 1/26/2026
Time: 11:15:24 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Front **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 161.6 Degrees F.

Comment:

Violation Issued?: No



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

TRADITIONS OF WATERVILLE
117 Paquin Street East
Waterville, MN 56096
Le Sueur County
Parcel:

Phone:

License Info

License: HFID 30618

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

Inspection Info

Report Number: F1034261015
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:09:43 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B Priority Level: Priority 3 CFP#: 43

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

COMMENT: The dispensing utensil for the sugar does not have a handle. The dispensing utensil must have a handle so that the food contact surface is not contaminated by hands.

Comply By: 1/22/2026 Originally Issued On: 1/20/2026

New Order: 4-200 Equipment Design and Construction

4-201.11GMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: Coolers in memory care and activities area are domestic coolers. Discussed requirements to meet code. TCS foods will be brought back to main kitchen at the end of the day, if any remain.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: Need an irreversible thermometer for the dishwasher. It should be run through the dishwasher at least 3 times per week. The temperature must reach at least 160 degrees F.

Comply By: 1/25/2026 Originally Issued On: 1/20/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: Need quat test strips for quaternary ammonium-based sanitizer. The dispenser must be tested at least 3 times per week. Solution should be 200-400ppm.

Comply By: 1/25/2026 Originally Issued On: 1/20/2026

! New Order: 4-500 Equipment Maintenance and Operation4-501.114F *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805F Provide and maintain a chemical sanitizer generated by a device on site at the food establishment that complies with 7US Code 136 to 136q, 40CFR.152.500 and 156.10, displays the US EPA device manufacturing facility registration number on the device and is operated and maintained according to manufacturer's instructions.

COMMENT: The sanitizer dispenser tested at 0 ppm quat. It should test at 200-400ppm. Call repair company to fix. Sanitizer will be manually mixed until dispenser is fixed.

Comply By: 1/25/2026 Originally Issued On: 1/20/2026

! New Order: 4-700 Sanitizing Equipment and Utensils4-703.11B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: The utensil surface temperature only reached 149 degrees, even after multiple runs. Call Martin Bros to come repair the dishwasher.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

New Order: 4-900 Protecting Clean Items4-903.11A *Priority Level: Priority 3 CFP#: 44*

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: The paper towel dispenser is currently placed right above where the clean dishes get put when air drying. The paper towel dispenser must be relocated to an area where hands will not contaminate clean dishes.

Comply By: 1/25/2026 Originally Issued On: 1/20/2026

New Order: 5-200A Plumbing: approved materials/design5-203.11A *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

COMMENT: A handwashing sink is required in the memory care kitchenette. One of the sinks must be dedicated as a handwashing sink and labeled as such.

Comply By: 1/21/2026 Originally Issued On: 1/20/2026

Food & Beverage General Comment

Inspection conducted in conjunction with HRD nursing evaluator Wendy Buckholz.

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 Mankato District Office inspection report number F1034261015 from 1/20/2026

Jessica Bluhm
LALD



McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Page: 1

Establishment Info

TRADITIONS OF WATERVILLE
Waterville
County/Group: Le Sueur County

Inspection Info

Report Number: F1034261015
Inspection Type: Full
Date: 1/20/2026
Time: 11:09:43 AM

Food Temperature: **Product/Item/Unit:** Stuffing; **Temperature Process:** Cold-Holding

Location: 2-Door Cooler at 38.7 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Rice; **Temperature Process:** Hot-Holding

Location: Steam Table at 179 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Noodles; **Temperature Process:** Hot-Holding

Location: Steam Table at 165 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Steak; **Temperature Process:** Hot-Holding

Location: Steam Table at 194 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Chicken and Rice; **Temperature Process:** Cooking

Location: Flat Top at 191 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Lunchmeat; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 35.9 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: 2-Door Cooler at 38.5 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Pie; **Temperature Process:** Cold-Holding

Location: Memory Care at 41.0 Degrees F.

Comment:

Violation Issued?: No



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Page: 1

Establishment Info

TRADITIONS OF WATERVILLE
Waterville
County/Group: Le Sueur County

Inspection Info

Report Number: F1034261015
Inspection Type: Full
Date: 1/20/2026
Time: 11:09:43 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: 3-Comp Sink **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Front **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 149.8 Degrees F.

Comment: Wash temp: 135

Rinse temp: 179

*these are also too low

Violation Issued?: Yes

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL30618016	Date: 1/20/2026
Facility Name: Traditions of Waterville	
Facility Address: 117 Paquin Street East Waterville, MN 56096	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: Resident room 11, 2nd floor fire door, storage room by link, link door by stairs were either propped opened or did not close and latch under their own power.
3. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: There was excessive lint behind the dryers in the 1st floor laundry room by room #108 and the 2nd floor laundry room A wing.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: There was an orange extension cord to a commercial freezer in 1st floor electrical room and an extension cord through door to the warmer in the kitchen and through the door in the LZ Rogers room.

5. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: A wing resident room smoke alarms (only) are over 10 years old from date of manufacture.

6. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: There was no carbon monoxide protection in the A wing.

7. The emergency power system shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

Comments: Exit/Emergency Lights failed operate when push button tested: Exit light northside by fire doors and by main entrance. Emergency lights: By resident room #102 and A wing south stairwell. All emergency and exit lights shall be push button tested monthly and the required annual test completed. This must be documented.

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

Comments: There were holes observed in the corridor wall and ceiling in the storage room under the step by the main front door and in the ceiling in the mechanical room and in storage room M-O as well as a vent/fan cut in wall storage room by link.

9. A working space of not less than 30 inches (762 mm) in width, 36 inches (914 mm) in depth and 78 inches (1981 mm) in height shall be provided in front of electrical service equipment. Where the electrical service equipment is wider than 30 inches (762 mm), the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: An electrical panel in the kitchen was blocked by a table.

10. Hoods, grease-removal devices, fans, ducts and other appurtenances shall be cleaned at intervals as required by Sections 607.3.3.1 through 607.3.3.3. [Minn. Stat. 144G.45 subd. 2; MSFC 607.3.3]

Comments: Excessive grease was observed behind the kitchen equipment.