



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2025

Licensee
Autumn Grace II
110 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL23858016

Dear Licensee:

On July 22, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 23, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 23, 2024, found not corrected at the time of the July 22, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0100-License Required-144g.10 Subdivision 1 - \$500.00
1890-Prescription Drugs-144g.71 Subd. 20 - \$500.00
2140-Supervising Staff Training-144g.83 Subd. 3 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 22, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 22, 2025, we identified the following violation(s):

1770-Documentation Of Medication Setup-144g.71 Subd. 9
2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

the website listed above.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Autumn Grace II. **Please contact odi Johnson at 507-344-2730 on or before Wednesday, October 22, 2025, to schedule the conference call.**

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

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: 23858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/22/2025
NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE II		STREET ADDRESS, CITY, STATE, ZIP CODE 110 RAVEN COURT MANKATO, MN 56001			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL23858016-1 On July 21, 2025, through July 22, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 23, 2024. At the time of the survey, there were thirteen (13) residents receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 100} SS=F	144G.10 Subdivision 1 License required	{0 100}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 100}	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	{0 100}			

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{0 100}	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants reside on one side of the building and was operated under another health care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the licensee's previous survey completed on December 23, 2024, the licensee identified one side of the licensee's building was licensed	{0 100}			

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{0 100}	Continued From page 3 under 245D and was not separated by an approved fire rated wall. The licensee had operated with two separate licensees (144G and 245D) in the same building. On July 21, 2025, at 10:00 a.m., executive director/licensed assisted living director (ED/LALD)-B stated since the time of the previous survey, the licensee had been working with the Minnesota Department of Health (MDH) to develop a plan for a waiver or architectural changes the licensee could complete to allow for both licenses to be within the same building. ED/LALD-B stated an approved plan had not been developed and was not sure when completion of the plan would occur. On July 21, 2025, at 11:45 a.m., the MDH engineer completed their review of the licensee's current building design and stated the licensee had removed a keypad locked door which separated the two differently licensed areas to comply with fire escape requirements. By removing the keypad locked door, the two sides of the building were connected and no longer had any separation between them. On July 21, 2025, at 12:15 p.m., ED/LALD-B stated licensee was aware having two separate licenses operating in the same building was in violation of the 144G statute but licensee would continue to work on a solution with MDH to allow for both licenses to be in compliance with statute. 144G.08 DEFINITIONS Subd. 7. Assisted living facility. Assisted living facility means a facility that provides sleeping accommodations and assisted	{0 100}			

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{0 100}	Continued From page 4 living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include: (1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361; (2) a nursing home licensed under chapter 144A; (3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56; (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D, 245G, or 245I; (5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D; (6) a private home in which the residents are related by kinship, law, or affinity with the provider of services; (7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593; (9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing; (10) housing financed pursuant to sections	{0 100}			

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{0 100}	Continued From page 5 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services; (11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q; (12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56; (13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or (15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence. Minnesota Statutes 144G.08 Definitions. Subdivision 59. "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 59. Resident. Resident means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 5. Assisted living contract. Assisted living contract means the legal	{0 100}			

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{0 100}	Continued From page 6 agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. No further information was provided.	{0 100}			
{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;	{0 480}			

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{0 480}	Continued From page 7 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01770	Not reviewed during this survey.		

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01770	Continued From page 8 review, the licensee failed to ensure documentation of medication set up was completed for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 22, 2025, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-R provide medication administration to R5. ULP-R obtained a pill organizer (a plastic container with individual compartments labeled for each day of the week used for organizing medications) which contained two (2) different doses of R5's olanzapine (an anti-psychotic medication used to commonly treat schizophrenia and bipolar disorder). A 15 mg (milligram) and 5 (five) mg pill of olanzapine was included in each day of week in the pill organizer. ULP-R removed the two individually wrapped pills, removed them from their foil packaging, placed them in a medication cup, and administered the medications to R5. ULP-R stated the medications were removed from their original boxes delivered by the pharmacy and placed in the pill organizer by clinical nurse supervisor (CNS)-C for administration to R5 to ensure R5 received the full 20 mg dose of olanzapine.	01770			

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01770	Continued From page 9 R5 was admitted to the licensee on October 5, 2021, with diagnoses which included paranoid schizophrenia, unspecified psychosis, and anxiety disorder. R5's Service Plan authenticated September 1, 2024, indicated R5 received the service of, "Medication set-up as ordered by physician," on a monthly basis performed by a TMA (trained medication aide), LPN (licensed practical nurse), or RN (registered nurse). R5's MAR (medication administration record) dated July 2025, indicated R5 had an order for olanzapine ODT (oral disintegrating tablet) 15 mg tablet and olanzapine ODT 5 mg tablet, both administered one time a day to equal a 20 mg total dose. On July 22, 2025, at 8:45 a.m., CNS-C stated R5's record would not have any documentation of medication set-up as the licensee were not aware placing the olanzapine in the pill organizer qualified as medication set-up. The licensee's Storage of Medications policy dated February 22, 2024, indicated medications would be stored in their original packaging until set up by a nurse for administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	{01890}			

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{01890}	Continued From page 10 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to remove expired medications from use for three residents (R5, R6, R12) whose medications were stored in a medication cart. 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: On July 21, 2025, at 1:00 p.m., the surveyor conducted a medication cart audit. Three medications for R5, R6, and R12 were noted as expired as they were dispensed greater than one year ago. The medications were provided to clinical nurse supervisor (CNS)-C. R5 R5 was admitted on October 5, 2021. R5's PRN (a medication that is administered, "pro re nata," which is Latin for, "as needed,")	{01890}			

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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
{01890}	Continued From page 11 senna tablets were dispensed on March 15, 2024. R6 R6 was admitted on November 22, 2023. R6's PRN acetaminophen tablets were dispensed on July 15, 2024. R12 R12 was admitted July 1, 2024. R12's PRN loratadine tablets were dispensed on July 2, 2024. R5, R6, and R12's MAR (medication administration records) were reviewed, and no expired medications were administered to any identified residents. On July 21, 2025, at 1:30 p.m., CNS-C stated medications expire one year from dispense date and the expired medications should have been identified during medication cart audits, removed from the medication cart, and disposed accordingly. CNS-C stated the licensee was not sure why the medications were not identified during medication cart audits. The licensee's Tag cited: 144G.71 Subdivision 20. Prescription drugs dated March 20, 2025, identified by executive director/licensed assisted living director (ED/LALD)-B as licensee's plan of correction (POC) read, "Med cart audits by med techs 4x (four times) a week and RN (registered nurse)/WC (wellness coordinator) weekly. Staff meetings monthly." The licensee's Mediation Program policy dated	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 12 February 28, 2024, indicated expired medications would be disposed of as soon as practical. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01890}			
{02140} SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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	{02140}			

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{02140}	Continued From page 13 portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living Facility with Dementia Care (ALFDC). CNS-C's employee record indicated she had completed a course through National Council of Certified Dementia Practitioners on August 19, 2024. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed and National Council of Certified Dementia Practitioners was not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On July 21, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-C stated they were responsible to provide direct resident cares and supervision of unlicensed staff. CNS-C stated they completed a dementia training course online which licensee thought met the requirements. The licensee's Assisted Living with Dementia Care Dementia Training policy dated February 2, 2022, indicated persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia including completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.	{02140}			

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{02140}	Continued From page 14 The licensee's Tag cited: 144G.83 Subdivision 3. Supervising staff training dated March 20, 2025, was identified by executive director/licensed assisted living director (ED/LALD)-B as licensee's plan of correction (POC) documentation. The document read, "dementia training to be completed as required by the commissioner." No further information was provided.	{02140}			
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 interview and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for one of one resident (R5) who had medication setup completed by unlicensed personnel (ULP) and failed to store oxygen (O2) in a safe manner for one of one resident (R14). 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	02310			

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02310	Continued From page 15 situation has occurred only occasionally). The findings include: MED SETUP On July 22, 2025, at 7:12 a.m., the surveyor observed ULP-R provide medication administration to R5. ULP-R obtained a pill organizer (a plastic container with individual compartments labeled for each day of the week used for organizing medications) which contained two (2) different doses of R5's olanzapine (an anti-psychotic medication used to commonly treat schizophrenia and bipolar disorder). A 15 mg (milligram) and 5 mg pill of olanzapine was included in each day of week in the pill organizer. ULP-R removed the two individually wrapped pills, removed them from their foil packaging, placed them into a medication cup, and administered the medications to R5. ULP-R stated the medications were removed from their original boxes delivered by the pharmacy and placed into the pill organizer by clinical nurse supervisor (CNS)-C for administration to R5 to ensure R5 received the full 20 mg dose of olanzapine. ULP-R further stated that on occasion, ULPs would also setup the medications into the pill organizer for R5 when CNS-C was busy. R5 was admitted to the licensee on October 5, 2021, with diagnoses which included paranoid schizophrenia, unspecified psychosis, and anxiety disorder. R5's Service Plan authenticated September 1, 2024, indicated R5 received the service of "Medication set-up as ordered by physician," on	02310			

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02310	Continued From page 16 a monthly basis performed by a TMA (trained medication aide), LPN (licensed practical nurse), or RN (registered nurse). R5's MAR (medication administration record) dated July 2025, indicated R5 had an order for olanzapine ODT (oral disintegrating tablet) 15 mg tab and olanzapine ODT 5 mg tab both administered one time a day to equal a 20 mg total dose. On July 22, 2025, at 8:45 a.m., CNS-C stated the licensee was not aware R5's olanzapine being placed into a pill organizer by the ULPs was classified as medication setup. CNS-C stated if they knew it was classified as "medication setup," the ULPs would not be allowed to complete that task as licensee knew only a nurse or pharmacist would setup medications for administration to a resident. The licensee's Storage of Medications policy dated February 22, 2024, indicated medications would be stored in their original packaging until setup by a nurse or pharmacist for future administration. Per Minnesota Statute 144G. 08 Definitions. Subd. 41.Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. O2 STORAGE On July 21, 2025, at 1:15 p.m., the surveyor observed R14's room door with an 'oxygen in use' warning sign. The surveyor observed seven O2 canisters free standing on the floor in R12's room and one canister sitting on R14's scooter	02310			

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02310	Continued From page 17 and leaning on the scooter's arm rest. No O2 storage rack was observed around the canisters or on the scooter. R14 was admitted on February 20, 2025, with diagnosis of chronic obstructive pulmonary disease (COPD, a disease that affects a person's ability to breathe), anxiety disorder, and mild cognitive impairment. On July 21, 2025, at 1:30 p.m., ED/LALD-B and CNS-C both stated R14's O2 should be stored in an appropriate O2 canister rack. ED/LALD-B stated R14 had a storage rack in their room, but R14 would remove the canisters from the rack and place them onto the floor. CNS-C stated the O2 canisters would need to be removed and stored in an area where the canisters would remain in the appropriate storage rack to prevent accidents. The licensee's undated, Safe Oxygen Use and Storage policy indicated O2 should be stored in a dedicated room, in an upright position, and secured to prevent from falling over. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 14, 2025

Licensee
Autumn Grace II
110 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL23858016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 23, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 for widespread violations;

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

Level 4: a fine of \$5,000 per incident, 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:

0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Autumn Grace II. Please contact Jodi Johnson at 507-344-2730 on or before Wednesday, March 19, 2025, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEpHVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

JMD

Minnesota Department of Health

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23858016-0 On December 17, 2024, through December 20, 2024, and December 23, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 14 residents; 14 residents were receiving services under the Assisted Living Facility with Dementia Care license. 0470: An immediate correction order was issued on December 20, 2024, at a level 3/Widespread (I). Action was taken to mitigate the risk; however, the scope and level remains at I. 1290: An immediate correction order was issued on December 19, 2024, at a level 3/Widespread (I). Action was taken to mitigate the risk; however, the scope and level remains at I. 2310: An immediate correction order was issued	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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0 000	Continued From page 1	0 000			
0 100 SS=F	on December 20, 2024, at a leve 3/Pattern (H). Action was taken to mitigate the risk; however, the scope and level remains at H. 144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants reside on one side of the building and was operated under another health care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 18, 2024, at at 7:25 a.m. during a medication pass observation, unlicensed personnel (ULP)-D went through a hard wood door with a locked keypad entry with a sign indicating "Vent [ventilator] staff only no exceptions". ULP-D stated R8 was an assisted living resident, but his room was actually on the "other side". She then entered R8's room and administered his medications, exited his room and again went through the door leading back	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 into the assisted living area of the building. ULP-D stated R8 enters and exits the assisted living by going through the shared bathroom with R10 and then going through R10's room, which enters directly into the assisted living area of the building. On December 18, 2024, at 1:48 p.m., regional director of operations/assisted living director in residency (RDO/ALDIR)-A and clinical nurse supervisor (CNS)-C stated they separated part of the area of the building out years ago and it was licensed under 245D and it had never been a problem in the past. The area serves four residents with either vent care or heavy physical cares under the 245D license at the address of 108 Raven Court. The address licensed as the Assisted Living with Dementia Care with this survey was 110 Raven Court. 144G.08 DEFINITIONS Subd. 7. Assisted living facility. Assisted living facility means a facility that provides sleeping accommodations and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include: (1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361; (2) a nursing home licensed under chapter 144A; (3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56; (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D,	0 100			

Minnesota Department of Health

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0 100	Continued From page 4 245G, or 245I; (5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D; (6) a private home in which the residents are related by kinship, law, or affinity with the provider of services; (7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593; (9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing; (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services; (11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q; (12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e,	0 100			

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0 100	Continued From page 5 or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56; (13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or (15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence. Minnesota Statutes 144G.08 Definitions. Subdivision 59. "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 59. Resident. Resident means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 5. Assisted living contract. Assisted living contract means the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services	0 110			

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0 110	Continued From page 6 and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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: On December 17, 2024, at 9:21 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated there was no active LALD listed for health facility identification number (HFID) 23858. During the entrance conference on December 17, 2024, at 11:40 a.m., regional director of operations/assisted living director in residency (RDO/ALDIR)-A stated the previous LALD left employment in October 2024, and since that time, she had been the acting ALDIR. She was listed as the director of record for the facility's other licensed facility and had the paperwork to complete to be a shared director but had not completed it yet. RDO/ALDIR-A further stated LALD-B had been hired on December 16, 2024,	0 110			

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0 110	Continued From page 7 and also had been listed as the director of record for the licensee's other facility but had not completed the shared director paperwork yet. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470			

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0 470	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's assessments and service plans on a 24-hour per day basis. This had the potential to affect all residents, staff, and visitors. This resulted in an immediate correction order on December 20, 2024. 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: On December 20, 2024, at 1:21 p.m., R11 was observed pushing on the inside exit door leading to the front entrance/exit of the facility. The door began alarming when R11 pushed on the release bar that enables the door to be opened. R11 continued to push on the release bar on the door until the door eventually opened. R11 walked into and through the entryway, through the exit door of the building, and headed towards the parking lot. At this time, unlicensed personnel (ULP)-Q was observed exiting a resident room and rushing towards the front entrance. ULP-Q exited the building, intercepted R11 in the parking lot, then walked R11 to the sister facility that shared the lot with the licensee. ULP-Q and R11 were observed	0 470			

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0 470	Continued From page 9 entering the sister facility together and at 1:23 p.m., ULP-Q returned to the licensee. ULP-Q stated he did not have a key to disable the alarm as the other ULP on duty was on her lunch break. ULP-Q then stated he was going to go over to the sister facility again to find someone who could disable the alarm. ULP-Q exited the facility at 1:26 p.m., walked across the parking lot to the sister facility, then returned at 1:27 p.m. with another staff member who disabled the alarm. On December 20, 2024, at 1:45 p.m., ULP-Q stated he was the only direct care staff in the facility when R11 exited the building. ULP-Q stated being aware one staff needed to be in the building at all times but could not let R11 be outside by himself. On December 20, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-C stated the licensee was staffed with two ULPs on the day and evening shift; one staff was to remain in the building at all times. If one of the two ULPs were out of the building and a resident exited the building, staff were directed to call for assistance at the sister facility across the parking lot. The licensee's Direct Care Staffing Plan reviewed July 3, 2023, indicated: There will be a 24 hour awake staff available to respond to resident requests for assistance with health and safety needs. Requirements for staff are available in the staffing policy. Staffing policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470			

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0 470	Continued From page 10 The licensee took action to mitigate the risk to residents on December 20, 2024; however, the scope and level remains at I. Staffing plan In addition, the licensee failed to ensure the required staffing plan was evaluated twice a year as required. The licensee's Direct Care Staffing Plan was dated July 3, 2023. The staffing plan had not been reviewed twice a year as required. On December 23, 2024, at 9:15 a.m., clinical nurse supervisor (CNS)-C stated the staffing plan dated July 3, 2023, was the most current and it should have been reviewed twice a year. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated February 22, 2024, identified "The staffing plan will be evaluated for the appropriately [sic] of staffing levels in the facility and revised as needed at a minimum of two times per year." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	0 480			

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0 480	Continued From page 11 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480			

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0 480	Continued From page 12 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 500	Continued From page 13	0 500			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 500			

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0 500	Continued From page 14 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 17, 2024, at 11:40 a.m., regional director of operations/assisted living director in residency (RDO/ALDIR)-A stated she was aware of the current minimum assisted living regulations and requirements of 144G.41. During the survey from December 17, 2024, through December 23, 2024, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents.	0 500			

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0 500	Continued From page 15 The licensee failed to implement policies and procedures to address the following: Requirements in section 626.557, reporting of maltreatment of vulnerable adults -Refer to licensing order 0630, at MN Statute 144G.42 Subd. 6. (b). The licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R5). Conducting and handling background studies on employees - Refer to licensing order 1290 at MN Statute 144G.60 Subd. 1. The licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (cook (C)-G, maintenance manager (MM)-F, unlicensed personnel (ULP)-L) Orientation, training, and competency evaluations of staff, and a process for evaluating staff performance - Refer to licensing order 2140 at MN Statute 144G.83 Subd. 3. The licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. Infection control practices - Refer to licensing order 0510 at MN Statute 144G.41 Subd. 3. The licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for two of two employees (ULP-D, ULP-P). Conducting appropriate screenings, or	0 500			

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0 500	Continued From page 16 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards - Refer to licensing order 0660 at MN Statute 144G.42. Subd. 9. The licensee failed to ensure two-step tuberculin skin test (TST) was completed according to protocol for one of two employees (ULP-D). Medication and treatment management - Refer to licensing order 1730 at MN Statute 144G.71 Subd. 5. The licensee failed to ensure individual medication management plans contain all the required content for three of three residents (R1, R2, R5). - Refer to licensing order 1760 at MN Statute 144G.71 Subd. 8. The licensee failed to ensure medications were administered as ordered for two of three residents (R1, R2). - Refer to licensing order 1880 at MN Statute 144G.71 Subd. 19. The licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. - Refer to licensing order 1890 at MN Statute 144G.71 Subd. 19. The licensee failed to ensure time sensitive medications were labeled with the date opened, and failed to remove expired medication from use for one of one resident (R1). Delegation of tasks by registered nurses or licensed health professionals - Refer to licensing order 1750 at MN Statute 144G.71 Subd. 7. The licensee failed to ensure	0 500			

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0 500	Continued From page 17 two of two unlicensed personnel (ULP-P, ULP-N) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 510 SS=F	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 infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for two of two employees (unlicensed personnel (ULP)-D, ULP-P). 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	0 510			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 510	Continued From page 18 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D On December 17, 2024, during continuous observation, the surveyor observed ULP-D completing the following tasks: - at 11:27 a.m., ULP-D set up R2's oral medications for administration, went to R2's room, assisted R2 to sit upright and administered the medications. ULP-D returned to the medication cart. ULP-D did not use hand sanitizer or wash her hands; - at 11:31 a.m., ULP-D set up R3's oral medications for administration, brought the medications to R3, R3 refused the medications, ULP-D returned to the cart, put them in an envelope and documented them as refused. ULP-D stated she had completed her medication pass. ULP-D did not wash hands or use hand sanitizer, went to the kitchen area and began assisting with handing out meals. On December 18, 2024, during continuous observation, the surveyor observed ULP-D completing the following tasks: - at 7:25 a.m., ULP-D set up R8's oral medications for administration, went to R8's room and administered the medications. ULP-D returned to the medication cart; - at 7:32 a.m., ULP-D set up and administered R7's medications - R2's call light was sounding. ULP-D went to R2's room, and R2 stated she wanted to go to her	0 510			

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0 510	Continued From page 19 bed. The entry door alarm was sounding, so ULP-D left R2's room and went to the front door, and then returned to R2's room. ULP-D placed a transfer belt on R2, felt the bottom of R2's feet to check if she had gripper socks, placed slippers on her feet, assisted her to stand, walk to the bed, lay down, lift R2's legs into bed, remove the slippers, position her in bed, and straighten her blankets. ULP-D then left R2's room at 7:43 a.m. and returned to the medication cart; - at 7:47 a.m., ULP-D set up and administered R6's oral medications; - at 7:57 a.m., R2 call light was sounding, ULP-D entered room and R2 wanted to get up and go outside to smoke. ULP-D assisted R2 out of bed, got her dressed, and transferred her to a wheelchair. R2 requested a cup of coffee. ULP-D went to the kitchen and got coffee for R2 who took a drink. ULP-D then put on R2's coat, gloves and hat and took her outside to smoke. After R2 finished smoking, she assisted her back to her room; and - ULP-D then served R6 his breakfast plate in the dining room, and then plate and deliver R13's breakfast tray to R13's room. Throughout the continuous observations, ULP-D did not use hand sanitizer or wash her hands between the medications passes or between resident contact/cares. On December 19, 2024, during continuous observation, ULP-P was observed completing the following: - at 4:23 p.m., ULP-P stated she had just checked R1's blood glucose and it was 200. ULP-P removed insulin from the medication cart, went to R1's room, administered insulin, and returned to the medication cart; - at 4:32 p.m., ULP-P set up oral medications for R9, went to R9's room and administered and	0 510			

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0 510	Continued From page 20 returned to the medication cart; - ULP-P then assisted a resident to the dining room table. ULP-P did not use hand sanitizer or wash hands between medications passes or between resident contact. On December 18, 2024, at 9:49 a.m., clinical nurse supervisor (CNS)-C stated staff should be using hand sanitizer between every resident and washing hands after every three residents or if visibly soiled. Staff should be using hand sanitizer between every resident medication pass. The licensee's Hand Hygiene policy dated February 22, 2024, indicated: Hand washing shall be performed between resident cares and whenever direct physical contact with a 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 resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gowns e. Before eating and after using a restroom Use of Hand Sanitizers -- Soap and water must be used when hands look dirty, after using the bathroom and prior to preparing food. In other situations, alcohol-based hand sanitizers may be used instead of soap and water. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 630	Continued From page 21	0 630			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: R2 R2 was admitted on December 31, 2021, with diagnoses including Parkinson's disease (a brain	0 630			

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0 630	Continued From page 22 disorder that causes unintended or uncontrollable movements such as shaking, stiffness, and difficulty with balance and coordination), paranoid schizophrenia (serious mental health condition that affects how people think), anxiety, and spinal enthesopathy (a condition that causes inflammation or degeneration of the connective tissue in the spine). R2's service plan dated September 1, 2024, indicated R2 required services including medication administration, shower, dressing, grooming, bathing, transfer, ambulation, and behavior monitoring. The service plan did not indicate R2 required supervision with smoking. On December 18, 2024, at 7:57 a.m., R2 turned on her call light and requested to smoke. The surveyor observed R2 sitting in her recliner leaning heavily to the left. R2's left hand and elbow had contractures. ULP-D asked R2 to sit up. R2 was able to sit upright with some assistance. ULP-D assisted R2 into her wheelchair, put on her hat and her jacket and wheeled her out the patio door. When R2 was finished smoking, ULP-D assisted her back into the building and back to her room. On December 19, 2024, at 1:42 p.m., R2 was ambulating in the hallway with a ULP. The surveyor observed R2's jacket had numerous burn holes around the collar, along the opening of the left side of the jacket, and on the left sleeve of the jacket. On December 20, 2024, at 9:55 a.m., R2 stated sometimes staff go outside with her when she smokes and sometimes they do not. R2 further stated most of the time the staff stay close to the door; however, at times they leave and come	0 630			

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0 630	Continued From page 23 back to check on her to see if she is done. R2 says she hasn't burned herself while smoking, just her jacket. The surveyor observed three small brown circles on the back of her middle finger. When asked, R2 stated if they are burns, then it was a 'freak accident.' On December 20, 2024, at 11:24 a.m., clinical nurse supervisor (CNS)-C, stated staff are supposed to supervise R2 when she is outside smoking. They are to stay in the living room area and watch her through the door. They do not have to be outside with her; however, they should be watching her smoke. "We have determined she is not safe to smoke independently." R2's IAPP dated December 9, 2024, failed to identify if R2 was at risk for abuse and interventions to prevent abuse. R5 R5 was admitted on October 5, 2021, with diagnoses including paranoid schizophrenia, anxiety, chronic pain, and asthma. R5's service plan dated September 1, 2024, identified R5's services included dressing, grooming, bathing, and medication administration. On December 18, 2024, at 8:15 a.m. the surveyor observed ULP-D administering medications to R5. R5's IAPP dated September 9, 2024, failed to identify if R5 was at risk for abuse, was at risk to abuse others, and interventions to prevent abuse. On December 23, 2024, at 3:29 p.m., CNS-C stated the IAPP should include risk for abuse and	0 630			

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0 630	Continued From page 24 interventions to prevent abuse. CNS-C further stated R2 wasn't at risk because she could notify someone if she was being abused. They used the same tool in the electronic system for all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two-step tuberculin skin test (TST) was completed according to protocol for one of two employees (unlicensed personnel (ULP)-D).	0 660			

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0 660	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on October 6, 2023, and provided direct care services residents at the assisted living facility. ULP-D's employee record included a TB symptom screen dated September 27, 2023, and documentation indicating a first step TST was administered on September 27, 2023, at 3:10 p.m. and read on September 29, 2024, at 3:20 p.m. with negative results. ULP's second step TST was administered on October 16, 2023, at 3:00 p.m. and was read on October 17, 2023, at 3:30 p.m. The second step was read 24.5 hours after it was administered instead of 48-72 hours after administration as required. On December 19, 2024, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated she is unsure why the ULP-D's second step TST was read early. CNS-C further stated the TST should always be read 48-72 hours after administration. The Minnesota Department of Health (MDH) Tuberculin Skin Test Basics identifies "The skin test reaction should be read between 48 and 72 hours after administration." No further information was provided.	0 660			

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0 660	Continued From page 26	0 660			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Seven (7) days 144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all	0 680			

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0 680	Continued From page 27 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Plan dated February 1, 2024, indicated the Hazard Vulnerability Assessment (HVA) identified the most relevant threats to the facility included: - epidemic/pandemic - severe thunderstorm - snowfall - temperature extremes - draught - flood - ice storm - tornado However, the emergency preparedness binder lacked policies or procedures for these identified threats. The facility's missing persons policy was dated February 22, 2024, and was not reviewed quarterly as required. On December 23, 2024, at 3:23 p.m., clinical nurse supervisor (CNS)-C stated there should have been policies in the emergency preparedness binder for identified threats indicated in the HVA. CNS-C stated she was unaware the missing person policy needed to be reviewed quarterly.	0 680			

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0 680	Continued From page 28 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 19, 2024, the surveyor made the following observations:	0 700			

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0 700	Continued From page 29 At 4:23 p.m., unlicensed personnel (ULP)-P set up R1's medication, left the medication cart to go to R1's room with the laptop open and visible to any staff, resident, or visitor that would walk by. The open laptop screen included R1's name, picture, diagnoses, allergies, and medications. At 4:27 p.m., ULP-P returned to the medication cart and documented the medication. ULP-P then left the laptop screen open and visible to any staff, resident, or visitor with resident names, pictures, and room numbers, and ULP-P went to the dining room and began serving resident meals. At 4:32 p.m., ULP-P returned to the medication cart, set up R6's medications, and went to administer the medications. ULP-P left the screen open and visible to any staff, resident, or visitors that would walk by. The laptop screen included R6's name, picture, diagnoses, allergies, and medications. At 4:48 p.m., ULP-P left the laptop screen open and visible to any staff, resident or visitor with R5's private information visible including R5's name, picture, diagnoses, allergies, and medications. During this time, R10 and R7 were in the area. At 4:55 p.m., the laptop remained open and visible with R5's information visible. Throughout the observation, multiple residents were walking through the area to and from the dining room. Staff were walking through the area, and the surveyor was sitting at a table in the area near the laptop and medication cart. On December 20, 2024, at 3:03 p.m., clinical nurse supervisor (CNS)-C stated the laptop	0 700			

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0 700	Continued From page 30 screen should never be left open and visible. Staff should either fold the screen down or lock the screen when they walk away from it to protect resident information. The licensee's Confidentiality of Resident Records and Information and Access to Records dated February 22, 2024, indicated resident records and information would be kept confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730			

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0 730	Continued From page 31 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of services was in the resident's record as required for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 730			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 32 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's service plan dated September 1, 2024, indicated R2 required services including medication administration, shower, dressing, grooming, bathing, transfer, ambulation, and behavior monitoring. The service plan did not indicate R2 required supervision with smoking. R2's documentation of services dated December 1, 2024, through December 17, 2024, identified the following: - Oral care routine, requires assistance with oral cares every shift - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. - Dressing, requires assistance for dressing/undressing - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. - Bladder documentation every shift - missing documentation on night, day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Meal percentage documentation for 9:00 a.m., 11:00 a.m., 1:00 p.m., 2:30 p.m. 6:00 p.m., and 8:00 p.m. - missing documentation December 1, 2, 3, 4, 6, 10, 12, 15, 2024. - House keeping schedule for evening shift on December 12, 2024, was not documented. - Smoking assistance every shift - missing documentation on night, day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Bathing/showering - December 12, 2024, was	0 730			

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0 730	Continued From page 33 not signed as completed. - Observe behaviors every shift - missing documentation on night, day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Observe behaviors - has a history of behavioral expression or inappropriate behavior - missing documentation on night, day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Walking every shift - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. - Snack - 10:00 a.m., 2:00 p.m., and 7:00 p.m. - missing documentation on December 1, 2, 3, 4, 6, 10, 12, and 15, 2024. - Bathroom assistance every two hours - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Bowel documentation every shift - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Personal hygiene every shift - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. R5 R5's service plan dated September 1, 2024, indicated R5 received services including medication administration, shower, dressing, grooming, bathing, transfer, ambulation, and behavior monitoring. R5's documentation of services dated December 1, 2024, through December 17, 2024, identified the following: - Bed making - missing documentation on December 1, 2, 4, 6, 12, and 15, 2024. - Laundry assistance - missing documentation on December 12, 2024.	0 730			

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0 730	Continued From page 34 - Removal of trash, pick up, straighten up every shift - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Behavior monitoring every shift - missing documentation on December 1, 2, 3, 4, 6, 10, 12, 15, and 17, 2024. - Bladder documentation every shift - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Snack at 10:00 a.m., 2:00 p.m., and 7:00 p.m. - missing documentation on December 1, 2, 3, 4, 6, 10, 12, and 15, 2024. - Meal percentage - missing documentation on December 1, 2, 3, 4, 6, 10, 12, and 15, 2024. - Dressing - requires assistance for dressing and undressing - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. - Housekeeping - missing documentation on December 1, 2024. - Transfer assistance - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Bathing/shower assistance - missing documentation on December 1, 2024. - Bowel documentation - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. - Personal hygiene every shift - missing documentation on day and/or evening shift on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. No documentation noted for night shift. - Meal attendance - missing documentation on December 1, 2, 3, 4, 6, 12, 15, and 17, 2024. On December 23, 2024, at 10:07 a.m., clinical nurse supervisor (CNS)-C stated staff should be documenting all services provided. Some staff are less knowledgeable with the electronic system and therefore may not be completing the documentation as required.	0 730			

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0 730	Continued From page 35 The licensee's Resident records policy dated February 22, 2024, indicated documentation of all services provided would be in the resident record. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780			

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0 780	Continued From page 36 by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on December 18, 2024, from 11:08 a.m. through 11:43 a.m., with maintenance manager (MM)-F, the surveyor observed that only one means of egress was provided from this licensed area. There was an exterior door that led into a fenced patio area, but the fence had a locked gate that obstructed the path of egress. There was a door in a corridor that led to a different licensed area of the facility, but the door required a code to unlock which obstructed the path of egress. State Fire Code in Minnesota Rules, chapter 7511 requires at least two means of egress be provided. During same tour the surveyor observed illuminated exits signs mounted on the ceiling that indicated a direction of egress travel that led to an area of the building that was not provided with a means of egress. Exit signs shall be located to clearly indicate egress doors and the direction of egress travel to an approved means of egress from a building or building area.	0 780			

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0 780	Continued From page 37 During same tour the surveyor observed that the posted evacuation plan indicated an evacuation route that led to a locked door by resident room 16. Evacuation plans must show unobstructed evacuation routes that lead to the exterior of the building. Evacuation routes cannot pass through locked doors. MM-F verified the above conditions during the tour and stated they understood the requirements. During an interview on December 18, 2024, at 12:15 p.m. with MM-F the surveyor asked for the annual fire alarm testing and inspection reports. MM-F stated they would email the report. On December 31, 2024, at 8:15 a.m. MM-F stated in an email that no records for fire alarm testing and inspection were found. State Fire Code in Minnesota Rules, chapter 7511 requires fire alarm systems be inspected and tested at least annually. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 900 SS=B	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900			

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0 900	Continued From page 38 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a signed written contract prior to providing assisted living services for three of four residents (R2, R5, R8). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R2	0 900			

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0 900	Continued From page 39 R2 was admitted to the Assisted Living with Dementia Care (ALFDC) on December 31, 2021. R2's Resident Agreement was signed by R2 on August 31, 2021. R2's contract was not signed by the licensee as required. R5 R5 was admitted to the ALFDC on October 5, 2021. R5's Resident Agreement was signed by R2 on October 5, 2021. R5's contract was not signed by the licensee as required. R8 R8 was admitted to the ALFDC on March 31, 2022. R8's Resident Agreement was signed by R8 on March 17, 2022. R8's contract was not signed by the licensee as required. On December 19, 2024, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated the licensed assisted living director who had separated employment, should have signed the contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.	0 910			

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0 910	Continued From page 40 (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have the licensee's health facility identification (HFID) number listed on the contract as required for two of two residents (R2, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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: R2 R2 was admitted to the Assisted Living with Dementia Care (ALFDC) facility on December 31, 2021. R2's Resident Agreement was signed by R2 on August 31, 2021. R2's contract did not include the facility's HFID as required. R5	0 910			

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0 910	Continued From page 41 R5 was admitted to the ALFDC facility on October 5, 2021. R5's Resident Agreement was signed by R2 on October 5, 2021. R5's contract did not include the facility's HFID as required. On December 19, 2024, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated all the contracts would be the same and would not have the HFID. The contract should have included the HFID as required. CNS-C was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060			

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01060	Continued From page 42 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01060			

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01060	Continued From page 43 or has the potential to affect a large portion or all of the residents). The findings include: R1's After Visit Summary from the hospital dated December 18, 2024, indicated R1 had been hospitalized December 15, 2024, through December 18, 2024. On December 17, 2024, at 3:09 p.m. unlicensed personnel (ULP)-D stated R1 was transferred to the hospital on December 15, 2024. On December 17, 2024, at 3:40 p.m. clinical nurse supervisor (CNS)-C stated R1 had been transferred to the hospital on December 15, 2024. CNS-C stated R1, her legal representative and case manager had not been provided the required emergency relocation documentation as CNS-C was unaware that needed to be provided to them as soon as practicable, she thought it only needed to be provided to the ombudsman if R1 was hospitalized for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
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	01290			

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01290	Continued From page 44 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (cook (C)-G, maintenance manager (MM)-F, unlicensed personnel (ULP)-L). This had the potential to affect all residents residing in the facility. This resulted in an immediate order on December 19, 2024. This practice resulted in a level three violation (a violation that harmed a client/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 the potential to affect a large portion or all the residents). The findings include: C-G C-G was hired December 4, 2019, as a cook for the licensee. On December 18, 2024, at approximately 11:30	01290			

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01290	Continued From page 45 a.m., the surveyor observed C-G setting up plates of food for the residents and handing them to residents. C-G was in the dining area unsupervised with residents. C-G was not listed on the facility's NETStudy roster provided by the licensee. The licensee provided a Department of Human Services (DHS) Background Study Notice clearance letter dated December 18, 2019, for Health Facility Identification (HFID) 25816. ULP-D was listed in Department of Human Services (DHS) NETStudy 2.0 as affiliated December 4, 2019, and had a separation date of April 9, 2022. MM-F MM-F was hired December 10, 2021, as a maintenance manager for the licensee. On December 17, 2024, and December 18, 2024, during surveyor observations of the staff and residents, the surveyor observed MM-F completing maintenance work independently in the building, entering and exiting resident rooms, and common areas. MM-F communicated with the residents in passing and when entering the resident rooms. MM-F was listed on the facility's NETStudy roster as eligible December 10, 2021; however, the eligibility was listed as COVID-19 expired. ULP-L ULP-L was hired on January 31, 2022, to provide direct care services to the residents. The facility's staff schedule identified ULP-L worked December 13, 2024, and December 14,	01290			

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01290	Continued From page 46 2024, on the 3:00 p.m. to 11:00 p.m. shift. ULP-L was listed on the facilities NETStudy roster as eligible February 1, 2022; however, eligibility was listed as COVID-19 expired. On December 19, 2024, at 9:35 a.m., licensed assisted living director (LALD)-B stated all staff should have a background study. She was unsure why C-G was not showing up on the roster, but they where able to find the paper clearance letter. LALD-B was unaware the COVID-19 emergency studies had expired. On December 19, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-C stated C-G, MM-F, and ULP-L would have all had unsupervised contact with the residents while working. The licensee's Background Checks policy dated February 22, 2024, indicated "All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 19, 2024, action was taken to mitigate the risk to residents; however, the scope and level remains at I.	01290			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650			

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01650	Continued From page 47 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01650			

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01650	Continued From page 48 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 December 31, 2021, with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements such as shaking, stiffness, and difficulty with balance and coordination), paranoid schizophrenia (serious mental health condition that affects how people think), anxiety, and spinal enthesopathy (a condition that causes inflammation or degeneration of the connective tissue in the spine). R2's smoking assessment dated November 25, 2024, indicated R2 was not able to safely light her cigarette, was not able to safely extinguish her cigarette in an approved container, and R2's cigarettes and lighter were to be stored in the locked medication cart. Staff were to supervise R2 while smoking and a cigarette holder was to be utilized as needed. R2's service plan dated September 1, 2024, indicated R2 required services including medication administration, shower, dressing, grooming, bathing, transfer, ambulation, and behavior monitoring. The service plan did not indicate R2 required supervision with smoking. On December 18, 2024, at 7:57 a.m., R2 turned on her call light and requested to smoke. The surveyor observed R2 sitting in her recliner leaning heavily to the left. R2's left hand and elbow had contractures. Unlicensed personnel (ULP)-D asked R2 to sit up. R2 was able to sit upright with some assistance. ULP-D assisted R2	01650			

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01650	Continued From page 49 into her wheelchair, put on her hat and her jacket and wheeled her out the patio door. ULP-D positioned R2 next to a cigarette butt receptacle with her back to the glass patio door and ULP-D came back into the building. ULP-D stood next to the door leaning against the wall and with her back to the door. ULP-D was not able to directly visualize R2. R2 finished smoking and backed the wheelchair up to the door using her feet. ULP-D assisted her back into the building and back to her room. On December 19, 2024, at 1:42 p.m., R2 was ambulating in the hallway with a ULP. The surveyor observed R2's jacket had numerous burn holes around the collar, along the opening of the left side of the jacket, and on the left jacket sleeve. On December 19, 2024, at 2:50 p.m., ULP-M was in the common area near the entrance of the facility, the patio/smoking area could not be visualized. The surveyor asked to see the electronic system and what the instructions were for R2's smoking supervision. The electronic system identified "Staff to supervise resident while resident is smoking. Resident is not to be left unattended while smoking". ULP-M then walked to the patio smoking area and the surveyor followed. R2 was sitting outside with her back to the door. ULP-M opened the door and asked R2 if she was done smoking and she said no. ULP-M stepped back inside and stood with her back against the wall next to the door. ULP-M was not able to directly visualize the front of R2. R2 finished smoking and pushed her wheelchair back with her feet and ULP-M wheeled her back into the building. On December 19, 2024, at 3:15 p.m., ULP-M	01650			

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01650	Continued From page 50 stated R2 was not outside when she was speaking with the surveyor. ULP-M stated she wheeled R2 outside after. ULP-M stands at the door inside and watches R2 while she smokes. ULP-M stated R2's cigarettes and lighters are stored in a drawer in her room. On December 19, 2024, at 4:36 p.m., ULP-O brought R2 outside to smoke, placed her near the cigarette butt receptacle. ULP-O stayed outside with R2, standing behind her until she was done smoking. R2 had her back to ULP-O, so ULP-O would not have been able to directly visualize R2 smoking. On December 19, 2024, at 4:45 p.m., ULP-O stated staff were to supervise R2 by staying outside with her and watching her. On December 20, 2024, at 8:21 a.m., ULP-Q wheeled R2 outside and assisted her to light her cigarette. ULP-Q then walked away and began shoveling the patio. When R2 was done smoking, ULP-Q wheeled her back into the facility. On December 20, 2024, at 9:55 a.m., R2 stated sometimes staff go outside with her and sometimes they do not. R2 further stated most of the time the staff stay close to the door; however, at times they leave and come back to check on her to see if she is done. R2 says she hasn't burned herself, just her jacket. The surveyor observed three small brown circles on the back of her middle finger. R2 stated if they were burns, then it was a 'freak accident.' On December 20, 2024, at 10:29 a.m., ULP-Q stated he takes R2 out every hour to smoke. Sometimes R2 is able to light her cigarette herself and sometimes ULP-Q lights it for her.	01650			

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01650	Continued From page 51 ULP-Q supervises R2 by being outside with her. ULP-Q further stated sometimes he goes inside until R2 is done, but he watches to ensure she does not drop the cigarette. On December 20, 2024, at 10:36 a.m., ULP-N stated typically when R2 is smoking, staff supervise by being outside with her; however, when it is really cold outside they will wait inside. ULP-N stated she positions R2 where she can see her smoking and that is how she was trained to supervise her. If R2 is smoking more than one cigarette, R2 will independently light the second cigarette. On December 20, 2024, at 11:24 a.m. clinical nurse supervisor (CNS)-C, stated staff are supposed to supervise R2 when she is outside smoking. They are to stay in the living room area and watch her through the door. They do not have to be outside with her; however, they should be watching her smoke. "We have determined she is not safe to smoke independently.: On December 20, 2024, at 11:30 a.m., CNS-C, licensed assisted living director (LALD)-B, and the suveyor walked into the living room area, approaching the patio door and observed R2 to be outside, positioned alongside the building with her back to the door smoking. No staff were present outside or in the living room area supervising R2. CNS-C confirmed staff were not present and also that R2 could not be visualized while smoking. CNS-C directed a ULP that was sitting in the dining area with another resident to come and supervise the resident. CNS-C stated she had assessed R2 and care planned for her to be supervised when smoking. CNS-C further stated she has trained staff that they need to visualize R2 when she is smoking to ensure	01650			

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01650	Continued From page 52 safety. On December 23, 2024, at 3:29 p.m., CNS-C stated supervision of smoking should have been included on R2's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	01730			

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01730	Continued From page 53 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure individual medication management plans contain all the required content for three of three residents (R1, R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 On December 19, 2024, at 4:23 p.m., the surveyor supervised unlicensed personnel (ULP)-P administering insulin to R1.	01730			

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01730	Continued From page 54 On December 20, 2024, at 9:40 a.m., the surveyor observed ULP-P administering insulin and oral medications to R1. R1's service plan was requested but not provided. R1's Individualized Medication Management Plan dated December 6, 2024, did not include the medication management tasks that may be delegated to ULP as required. R2 On December 17, 2024, at 11:27 a.m., the surveyor observed ULP-D administering oral medications to R2. R2's Service Plan dated September 1, 2024, indicated R2's services included medication administration. R2's Individualized Medication Management Plan dated September 7, 2024, did not include the medication management tasks that may be delegated to ULP and did not include the description of medication storage as required. R5 On December 18, 2024, at 8:15 a.m. the surveyor observed ULP-D administering oral medications to R5. R5's Service Plan signed September 27, 2024, indicated R2's services included medication administration. R5's Individualized Medication Management Plan dated September 7, 2024, did not include the medication management tasks that may be delegated to ULP as required.	01730			

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01730	Continued From page 55 On December 23, 2024, at 11:26 a.m., clinical nurse supervisor (CNS)-C stated the medication management plans should include the type of medication storage and she would write in that it was the locked medication cart. CNS-C further stated all medication management plans would be the same document and were missing the tasks that can be delegated to the ULP. A policy for medication management plan was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-P, ULP-N) completed	01750			

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01750	Continued From page 56 insulin administration via a prefilled insulin pen according to manufacturer instructions. 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: R1's diagnoses included diabetes (the body's inability to adequately manage blood sugar), bipolar disorder (a mental illness that causes extreme mood swings), anxiety and stroke. R1's unsigned, care plan dated December 28, 2024, indicated R1 received services to include medication management, insulin injections and blood sugar checks. R1's Medication Administration Record (MAR) for December 1-15, 2024, and December 18-20, 2024, indicated the following: - Novolog insulin give 4 units subcutaneously with meals three times per day; although it was ordered with meals the scheduled times on the MAR were 8:00 a.m., 12:00 p.m. and 8:00 p.m.; - Novolog insulin per sliding scale at 8:00 a.m., 12:00 p.m., and 5:00 p.m. 0-120: Give 0 units, Contact RN; 121-140: Give 1 unit 141-160: Give 2 units 161-180: Give 3 units 181-200: Give 4 units	01750			

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01750	Continued From page 57 201-220: Give 5 units 221-240: Give 6 units 241-260: Give 7 units 261-280: Give 8 units 281-300: Give 9 units 300+: Give 10 units, Contact RN. On December 19, 2024, at 4:23 p.m., ULP-P stated R1's blood sugar was 200. ULP-P removed the pen cap, and placed a pen needle on the insulin pen. ULP-P dialed the pen to 4 units and administered the insulin into R1's abdomen and immediately removed the needle from the skin. ULP-P did not prime the pen needle with 2 units prior to administration of the 4 units, ULP-P did not clean R1's skin with an alcohol swab prior to administering the insulin, and ULP-P did not keep the needle in the skin for six seconds after administration of the dose. On December 20, 2024, at 9:40 a.m., ULP-N checked R1's blood sugar with a result of 172. ULP-N then removed the pen cap, and placed a pen needle on the insulin pen. ULP-N dialed the pen to 4 units and administered the insulin into R1's abdomen and held the needle in the skin for the recommended time prior to removal. ULP-N did not prime the pen needle with 2 units prior to administration of the 4 units, and ULP-N did not clean R1's skin with an alcohol swab prior to administering the insulin. ULP-N stated a nurse had trained her how to administer the insulin. On December 20, 2024, at 3:03 p.m., clinical nurse supervisor (CNS)-C stated when administering insulin, staff should place the needle on the insulin pen, dial the pen to 2 units and waste, then staff should dial the pen to the correct dose, clean the resident's skin with an alcohol swab, administer the insulin and hold the	01750			

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01750	Continued From page 58 needle in the skin for 10 seconds after administration. Novolog's prescribing information dated February 2015 included the following: - after placing the pen needle, "Turn the dose selector to 2 units. Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Press and hold in the dose button until the dose counter shows "0". A drop of insulin should be seen at the needle tip." - "Choose your injection site and wipe the skin with an alcohol swab. Let the injection site dry before you inject your dose." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=E	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.	01760			

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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
01760	Continued From page 59 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as ordered for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R1 On December 19, 2024, at 4:23 p.m., the surveyor observed unlicensed personnel (ULP)-P administering Novolog insulin 4 units to R1. On December 20, 2024, at 9:40 a.m., the surveyor observed ULP-N checking R1's blood sugar with a result of 172, and administered Novolog 4 units of insulin. R1's Medication Administration Record (MAR) for December 1-15, 2024, and December 18-20, 2024, indicated the following: - Novolog insulin give 4 units subcutaneously with meals three times per day; although it was ordered with meals the scheduled times on the MAR were 8:00 a.m., 12:00 p.m. and 8:00 p.m. and the insulin had been administered at those times. - Novolog insulin per sliding scale at 8:00 a.m.,	01760			

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01760	Continued From page 60 12:00 p.m., and 5:00 p.m. 0-120: Give 0 units, Contact RN; 121-140: Give 1 unit 141-160: Give 2 units 161-180: Give 3 units 181-200: Give 4 units 201-220: Give 5 units 221-240: Give 6 units 241-260: Give 7 units 261-280: Give 8 units 281-300: Give 9 units 300+: Give 10 units, Contact RN. On December 20, 2024, at 8:00 a.m. blood sugar was documented as 172 but the insulin was document as not given with reason of "just gave 4 units". On December 23, 2024, at 3:08 p.m., clinical nurse supervisor (CNS)-C stated on December 19, 2024, at 5:00 p.m., R1 should have received 8 units of insulin because her blood glucose was 200; however, because the MAR was incorrect, R1 received the wrong dose at mealtime. CNS-C further stated the MAR should have had the Novolog sliding scale insulin scheduled at 8:00 a.m., 12:00 p.m., and 5:00 p.m. Novolog sliding scale had been administered at the wrong time (8:00 p.m. instead of 5:00 p.m.) the entire month. CNS-C stated she was unaware staff had administered only 4 units Novolog insulin on December 20, 2024. R1's blood sugar was 172, therefore she should have received Novolog 4 units scheduled dose and Novolog 3 units sliding scale dose for a total of 7 units. R2 On December 17, 2024, at 11:27 a.m., the surveyor observed ULP-D administering medications to R2	01760			

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01760	Continued From page 61 R2's Service plan dated September 1, 2024, indicated R2 received services including medication management and administration. R2's physician orders dated November 13, 2024, included erythromycin eye ointment apply 1 strip into left eye at bedtime. R2's Medication administration record for December 1-18, 2024, identified erythromycin 1 strip into left eye at bedtime was discontinued on December 11, 2024. On December 23, 2024, at 3:08 p.m., CNS-C stated R2's erythromycin was still an active order, and something must have happened with the computer system and it dropped off the MAR on December 11, 2024. CNS-C further stated, the staff were still administering the medication although it was not on the MAR and was not documented as given. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880			

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01880	Continued From page 62 review, the licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 19, 2024, at 4:23 p.m., unlicensed personnel (ULP)-P removed a plastic box containing two insulin pens from the medication cart. ULP-P took the insulin aspart pen into R1's room to administer the insulin and left the Lantus insulin pen unattended on top of the med cart. The insulin pen was visible and accessible to other residents, staff, and visitors in the facility. ULP-P returned to the medication cart at 4:27 p.m. and locked the insulin pens in the medication cart. On December 20, 2024, at 3:03 p.m., clinical nurse supervisor (CNS)-C stated medications should always be kept locked in the medication cart and should never be left unattended, unlocked, and on top of the medication cart accessible to others. The licensee's Storage of Medications policy dated February 22, 2024, identified medications would be stored per acceptable standards.	01880			

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01880	Continued From page 63 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened, and failed to remove expired medication from use for one of one resident (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: On December 17, 2024, at 3:09 p.m., the surveyor observed the following medications in the locked medication cart for R1:	01890			

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01890	Continued From page 64 - insulin aspart with an open date of August 8, 2024; - insulin aspart with an open date of November 19, 2024; and - Lantus insulin with an open date of November 9, 2024. On December 17, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated R1 went to the hospital and was admitted on December 16, 2024, and the aspart insulin dated August 8, 2024, and the Lantus insulin pen should have been removed and not used as they were beyond the 28 days from the date opened. CNS-C removed the insulin pens from the cart. On December 19, 2024, at 4:23 p.m., unlicensed personnel (ULP)-P was observed administering insulin to R1. The surveyor observed the aspart insulin and the Lantus insulin did not have an open date marked on either pen. On December 20, 2024, at 3:03 p.m., CNS-C stated the insulin pens should have had an open date on them and she had instructed the staff to mark them. The licensee's Storage of Medications policy dated February 22, 2024, indicated medications would be stored according to manufacturer recommendations. Novolog's (aspart) prescribing information dated February 2015, indicated the Novolog FlexPen you are currently using should be thrown away after 28 days even if it still has insulin in it. Lantus's prescribing information dated November 2018, indicated Lantus pen in use can be stored out of the refrigerator and can be used for 28	01890			

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01890	Continued From page 65 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	02140			

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02140	Continued From page 66 The findings include: The licensee was licensed as an assisted living facility with dementia care (ALFDC). CNS-C's employee record indicated she had completed a course through National Council of Certified Dementia Practitioners on August 19, 2024. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed and National Council of Certified Dementia Practitioners was not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On December 17, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-C stated she was responsible to provide direct resident cares and supervision of unlicensed staff. CNS-C stated she completed a dementia training course online which she was thought met the requirements, CNS-C was unaware of the Assisted Living FAQ's which listed the courses approved by the commissioner. The licensee's Assisted Living with Dementia Care Dementia Training policy dated February 2, 2022, indicated persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia including completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.	02140			

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02140	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140			
02320 SS=H	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 document review, the facility failed to ensure a resident was supervised while smoking. This resulted in an immediate correction order identified on December 20, 2024. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted on December 31, 2021, with	02320			

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02320	Continued From page 68 diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements such as shaking, stiffness, and difficulty with balance and coordination), paranoid schizophrenia (serious mental health condition that affects how people think), anxiety, and spinal enthesopathy (a condition that causes inflammation or degeneration of the connective tissue in the spine). R2's smoking assessment dated November 25, 2024, indicated R2 was not able to safely light her cigarette, was not able to safely extinguish her cigarette in an approved container, and R2's cigarettes and lighter were to be stored in the locked medication cart. Staff were to supervise R2 while smoking and a cigarette holder was to be utilized as needed. R2's service plan dated September 1, 2024, indicated R2 required services including medication administration, shower, dressing, grooming, bathing, transfer, ambulation, and behavior monitoring. The service plan did not indicate R2 required supervision with smoking. On December 18, 2024, at 7:57 a.m., R2 turned on her call light and requested to smoke. The surveyor observed R2 sitting in her recliner leaning heavily to the left. R2's left hand and elbow had contractures. Unlicensed personnel (ULP)-D asked R2 to sit up. R2 was able to sit upright with some assistance. ULP-D assisted R2 into her wheelchair, put on her hat and her jacket and wheeled her out the patio door. ULP-D positioned R2 next to a cigarette butt receptacle with her back to the glass patio door and ULP-D came back into the building. ULP-D stood next to the door leaning against the wall and with her back to the door. ULP-D was not able to directly	02320			

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02320	Continued From page 69 visualize R2. R2 finished smoking and backed the wheelchair up to the door using her feet. ULP-D assisted her back into the building and back to her room. On December 19, 2024, at 1:42 p.m., R2 was ambulating in the hallway with a ULP. The surveyor observed R2's jacket had numerous holes around the collar, along the opening of the left side of the jacket, and on the left sleeve of the jacket. On December 19, 2024, at 2:50 p.m., ULP-M was in the common area near the entrance of the facility, the patio/smoking area could not be visualized. The surveyor asked to see the electronic system and what the instructions were for R2's smoking supervision. The electronic system identified "Staff to supervise resident while resident is smoking. Resident is not to be left unattended while smoking". ULP-M then walked to the patio smoking area and the surveyor followed. R2 was sitting outside with her back to the door. ULP-M opened the door and asked R2 if she was done smoking and she said no. ULP-M stepped back inside and stood with her back against the wall next to the door. ULP-M was not able to directly visualize the front of R2. R2 finished smoking and pushed her wheelchair back with her feet and ULP-M wheeled her back into the building. On December 19, 2024, at 3:15 p.m., ULP-M stated R2 was not outside when she was speaking with the surveyor. ULP-M stated she wheeled R2 outside after. ULP-M stands at the door inside and watches R2 while she smokes. ULP-M states R2's cigarettes and lighters are stored in a drawer in her room.	02320			

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02320	Continued From page 70 On December 19, 2024, at 4:36 p.m., ULP-O brought R2 outside to smoke, placed her near the cigarette butt receptacle. ULP-O stayed outside with R2, standing behind her until she was done smoking. R2 had her back to ULP-O, so ULP-O would not have been able to directly visualize R2 smoking. On December 19, 2024, at 4:45 p.m., ULP-O stated staff were to supervise R2 by staying outside with her and watch her. On December 20, 2024, at 8:21 a.m., ULP-Q wheeled R2 outside and assisted her to light her cigarette. ULP-Q then walked away and began shoveling the patio. When R2 was done smoking, ULP-Q wheeled her back into the facility. On December 20, 2024, at 9:55 a.m., R2 stated sometimes staff go outside with her and sometimes they do not. R2 further stated most of the time the staff stay close to the door; however, at times they leave and just come back to check on her to see if she is done. R2 says she hasn't burned herself just her jacket. The surveyor observed three small brown circles on the back of her middle finger. R2 stated if they are burns, then it was a 'freak accident.' On December 20, 2024, at 10:29 a.m., ULP-Q stated he takes R2 out every hour to smoke. Sometimes R2 is able to light her cigarette herself and sometimes ULP-Q lights it for her. ULP-Q supervises R2 by being outside with her. ULP-Q further stated sometimes he does go inside until R2 is done, but he does watch that she does not drop the cigarette. On December 20, 2024, at 10:36 a.m., ULP-N stated typically when R2 is smoking, staff	02320			

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02320	Continued From page 71 supervise by being outside with her; however, when it is really cold outside they will wait inside. ULP-N stated she positions R2 where she can see her smoking and that is how she was trained to supervise her. If R2 is smoking more than one cigarette, R2 will independently light the second cigarette. On December 20, 2024, at 11:24 a.m. clinical nurse supervisor (CNS)-C, stated staff are supposed to supervise R2 when she is outside smoking. They are to stay in the living room area and watch her through the door. They do not have to be outside with her; however, they should be watching her smoke. "We have determined she is not safe to smoke independently.: On December 20, 2024, at 11:30 a.m., CNS-C, licensed assisted living director (LALD)-B, and the suveyor walked into the living room area, approaching the patio door and observed R2 to be outside, positioned alongside the building with her back to the door smoking. No staff were present outside or in the living room area supervising R2. CNS confirmed staff were not present and also that the resident could not be visualized smoking. CNS directed a ULP that was sitting in the dining area with another resident to come and supervise the resident. CNS-C stated she has assessed R2 and care planned for her to be supervised when smoking and can't fix what she didn't know about. CNS-C stated she has trained staff that they need to visualize the resident when she is smoking to ensure safety. The licence's undated, Smoking policy identified the following: - Residents assessed to be unsafe to smoke will require supervision while in the designated smoking areas.	02320			

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02320	Continued From page 72 - Staff training includes: · Smoking safety · Smoking materials · Assessing Residents who smoke for safe practices · Educating Residents, family members and others of fire safety · Monitoring Residents who smoke · Observing Residents for signs of inability to smoke safely · Reporting requirements" - A smoking assessment will be completed for each Resident who smokes at move-in, at the time of required re-assessments and upon a significant change." - "Residents who require supervision when smoking will be monitored by staff in the designated smoking areas. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 20, 2024, the licensee took action to mitigate the risk; however, scope and level remains at H.	02320			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a	02410			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE II		STREET ADDRESS, CITY, STATE, ZIP CODE 110 RAVEN COURT MANKATO, MN 56001			
(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
02410	Continued From page 73 lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for R10. 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: On December 18, 2024, at 7:25 a.m. during a medication pass observation, unlicensed personnel (ULP)-D went through a hard wood door with a locked keypad entry with a sign indicating "Vent staff only no exceptions". ULP-D stated R8 was an assisted living resident, but his	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE II			STREET ADDRESS, CITY, STATE, ZIP CODE 110 RAVEN COURT MANKATO, MN 56001		
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02410	Continued From page 74 room was actually on the "other side". She then entered R8's room and administered his medications, exited his room and again went through the door leading back into the assisted living area of the building. ULP-D stated R8 enters and exits the assisted living by going through the shared bathroom with R10 and then going through R10's room, which enters directly into the assisted living area of the building. On December 23, 2024, at 3:35 p.m., clinical nurse supervisor (CNS)-C stated R8 enters and exits the common area of the assisted living by going through the shared bathroom with R10, then going through R10's room. R10 doesn't care that R8 goes through his room. R8 could enter R10's room at any time even when/if R8 was having a private moment or not clothed. CNS-C further stated they had considered putting up a privacy curtain in the past, but had not done that. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410			



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

Type: Full
Date: 12/19/24
Time: 12:19:01
Report: 25100010

Food and Beverage Establishment Inspection Report

Page 1

Location:

Autumn Grace II
110 Raven Court
Mankato, MN56001
Blue Earth County, 07

Establishment Info:

ID #: 0018715
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

MS-AC Mankato AG Senior Living

Phone #: 5073880647
ID #: 46791

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

The following orders were issued during this inspection.

5-200A Plumbing: approved materials/design

5-203.11A **** Priority 2 ****

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.

Discontinue using the front area handwashing sink as a warewashing sink. The front area handwashing sink must only be used for handwashing.

Comply By: 01/06/25

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

The dish machine in the front service area does not meet ANSI standards and must be replaced.

Comply By: 01/06/25

Food and Equipment Temperatures

Process/Item: Upright Freezer

Temperature: 0 Degrees Fahrenheit - Location: Ambient

Violation Issued: No

Process/Item: Upright Freezer

Temperature: -5 Degrees Fahrenheit - Location: Ambient

Violation Issued: No

Type: Full
Date: 12/19/24
Time: 12:19:01
Report: 25100010
Autumn Grace II

Food and Beverage Establishment Inspection Report

Page 2

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	1	1

This inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 25100010 of 12/19/24.

Certified Food Protection Manager Ryan Wieneke

Certification Number: FM52916 Expires: 04/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ryan Wieneke
Food Service Manager

Signed:  _____

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