Electronically Delivered

February 22, 2023

Licensee
The Pillars Of Mankato
3125 Prairie Rose Drive
Mankato, MN 56001

RE: Project Number(s) SL34399015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

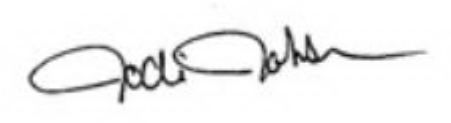
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34399	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF MANKATO	3125 PRAIRIE ROSE DRIVE 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 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: SL#34399015 On January 30, 2023, through February 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 122 residents, with 76 whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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) 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 30, 2023, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and 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, 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). Findings include: On 01/30/2023 between 11:00 AM TO 02:00 PM, survey staff observed that no documentation was presented during documentation review to confirm that evacuation drills are being conducted with employees twice per year shift per shift with at least one drill every other month. DM-E verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 4 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 5 The findings include: R1's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R1's diagnoses included mood disorder, cognitive impairment, hypertension (high blood pressure), hyperlipidemia (high cholesterol), benign prostatic hyperplasia (enlarged prostate), and anxiety. R1's Service Plan Agreement, effective July 5, 2022, indicated R1 received services including bathing, medication administration, cueing and standby assist with ADLs (activities of daily living), meals, laundry, and housekeeping. R1's assessments were requested on January 30, 2023. R1's last documented assessment was a 14-day assessment dated July 14, 2022; two hundred days had passed since R1's last assessment. On January 30, 2023, at approximately 1:30 p.m. RN-C confirmed R1's 90-day assessment had not yet been completed. RN-C stated they had a system in place to track when assessments were due, however, due to R1's pay source the system did not recognize the need for the assessment. The licensee's Assessment of Clients - Initial and Ongoing policy last reviewed May 23, 2022, indicated: The RN will determine the frequency of re-assessments based on the client's needs, with the frequency between assessments no more than 14 days after initiation of care and thereafter not to exceed 90 days from the last date of the assessment. No further information was provided.	01620		

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01620	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of five residents (R1). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 7	01640		

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:

R1's diagnoses included mood disorder, cognitive impairment, hypertension (high blood pressure), hyperlipidemia (high cholesterol), benign prostatic hyperplasia (enlarged prostate), and anxiety.

R1's Service Plan Agreement, effective July 5, 2022, indicated R1 received services including medication administration and medication set-up.

On January 30, 2023, at approximately 1:30 p.m. registered nurse (RN)-C stated R1 no longer was receiving medication set-up services. RN-C further stated when R1 first admitted to the facility he had his existing medications set-up in a medi-box until their pharmacy could provide the medications in bubble packs; since R1's 90-assessment had not been completed timely, the service plan subsequently had not been updated.

On January 31, 2023, at 7:48 a.m. unlicensed personnel (ULP)-D was observed administering medications to R1. There were no medications set-up in a medi-box.

The licensee's Service Plan Agreement Content policy revised August 1, 2021, indicated: All assisted living clients that are receiving assisted living service, have an up-to-date Service Plan

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01640	Continued From page 8 Agreement identifying service to be provided based on the assessment by the registered nurse. The Service Plan Agreement contains all required information and is signed by the RN and by the client and/or the client's representative. Any revisions to the Service Agreement are made based on changes in client's needs or preferences and any time our agency's fee schedule changes. The licensee's Service Plan Agreement Development and Revision policy revised August 1, 2021, indicated: 2. Revisions to the Service Plan Agreement b. If a review of the Service Plan indicates that the client's Service Plan Agreement needs modification based on the client's needs, preferences or changes in fees, the RN: Makes necessary changes to the Service Plan Signs the revised Service Plan with name, title and date Requests that the client and/or the client's representative sign and date the revised Service Plan Files the signed Service Plan in the client record No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	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,	01750		

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01750	Continued From page 9 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 delegated procedures were followed for one of three residents (R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included mood disorder, cognitive impairment, hypertension (high blood pressure), hyperlipidemia (high cholesterol), benign prostatic hyperplasia (enlarged prostate), and anxiety. R1's Service Plan Agreement dated July 5, 2022, indicated the resident received medication administration services provided by unlicensed personnel (ULP) three times daily. R1's medication administration record (MAR) dated January 2023, included an order for	01750		

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01750	Continued From page 10 Symbicort 160-4.5 mcg/ACT (micrograms/actuation) inhaler - inhale two puffs twice daily. Rinse mouth after use. On January 31, 2023, at 7:48 a.m., unlicensed personnel (ULP)-D was observed administering medications to R1 in his apartment. After R1 took his scheduled oral medications, ULP-D handed the resident his Symbicort inhaler. R1 took the inhaler and independently administered two puffs, waiting several seconds between each puff. When finished, R1 handed the inhaler back to ULP-D. R1 made no attempt to rinse his mouth after inhaling the medication nor did ULP-D prompt the resident to rinse his mouth afterwards. When interviewed at 8:01 a.m., following the medication administration observation, ULP-D confirmed she had not prompted R1 to rinse his mouth after utilizing the inhaler and further confirmed the order on the MAR and the label on the Symbicort inhaler box directed to do so. On February 1, 2023, at 3:01 p.m. director of health services (DHS)-B confirmed ULP-D should have prompted R1 to rinse mouth after inhaler use and further confirmed the resident's MAR directed to do so. The manufacturer Patient Information insert for Symbicort revised December 2017, and printed from the website on February 3, 2023, indicated: Rinse your mouth with water and spit the water out after each dose (2 puffs) of SYMBICORT. Do not swallow the water. This will help to lessen the change of getting a fungus infection (thrush) in the mouth and throat. No further information was provided.	01750		

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01750	Continued From page 11 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of six residents (R7). 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:	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 12 R7's diagnoses included chronic obstructive pulmonary disease (persistent respiratory symptoms like progressive breathlessness and cough), dementia (memory loss), and nicotine dependence (tobacco dependence). R7's Service Plan Agreement dated September 23, 2022, indicated R7 received services which included medication administration. R7's medication administration record (MAR) dated January 2023, included nicotine (replacement therapy) 14 milligrams (mg)/24-hour patch; place one patch on the skin daily; removed old patch before placing new patch every 24 hours; rotate sites for patch. Place patch on upper arm alternating sites. R7's physician orders dated December 22, 2022, included nicotine transdermal patch 14 mg/24 hours. Place one patch on the skin daily. Removed old patch before placing new patch every 24 hours. Rotate sites for patch. On January 31, 2023, at 7:50 a.m., unlicensed personnel (ULP)-I was observed to obtain R7's scheduled nicotine patch and brought to resident. ULP-I applied gloves and placed the nicotine patch on R7's right upper arm, and proceeded to remove gloves, sanitize hands and leave R7's room. At this time, evaluator asked ULP-I why she had not removed the old patch prior to placing the new patch and ULP-I responded the patch was removed at bedtime and the instructions needed to be updated on the MAR. On January 31, 2023, at 1:55 p.m., director of health services (DHS)-B stated R7 was not getting his nicotine patch for 24 hours as	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34399	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF MANKATO	3125 PRAIRIE ROSE DRIVE 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
01760	Continued From page 13 prescribed and this would be considered a medication error. DHS-B further indicated when the order was changed (from twice daily to once daily) on December 22, 2022, the order to remove patch at bedtime should have been taken off the MAR but was not. The licensee's Medication Management Services policy revised August 1, 2021, noted the RN or licensed practical nurse (LPN) would review each client's medication record at appropriate times based on the client's needs and medication management services, to verify staff are administering the medications as prescribed and are documenting the administration appropriately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34399	A. BUILDING: _____ B. WING _____	02/01/2023

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01910	Continued From page 14 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R6). 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 entrance conference on January 30, 2023, at 9:33 a.m., registered nurse (RN)-C stated when a resident discharged from the facility their medications were sent with them. RN-C stated narcotic medications were counted and recorded and confirmed non-narcotic medications were not counted or recorded and just given to the resident or their representative. If a resident passed away their medications were counted, recorded, and destroyed.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 15 R6's diagnoses included but were not limited to, cerebrovascular accident (stroke), hypertension (high blood pressure), hyperlipemia (high cholesterol), atrial fibrillation (an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart), and chronic kidney disease. R6's Service Plan dated September 29, 2022, indicated the resident received services including medication administration. R6's medication administration record (MAR) dated September 5, 2022, thru October 4, 2022, included but was not limited to, the following medications: one mild-moderate pain reliever, one anti-hypertensive medications (to reduce blood pressure), one antihyperlipidemic (to lower cholesterol), one lubricating eye drop, one inhaler, three vitamins, one platelet aggregation inhibitor (to prevent heart attacks and strokes in persons with heart disease (recent heart attack), recent stroke, or blood circulation disease), and one over active bladder medication. R6 discharged from the licensee on October 13, 2022, to a long term-care facility. R6's record lacked documentation of medication disposition upon the resident's discharge. On January 30, 2023, at 12:30 p.m., RN-C confirmed R6's record did not include a disposition of medications upon discharge. RN-C stated they bag up the medications and give to the resident or representative at time of discharge. The licensee's Disposition of Medication/Legend and Controlled Substance policy revised August	01910		

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01910	Continued From page 16 1, 2021, indicated: M. Staff will document in the client's record there name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R3) who had an open area on their skin. 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).	02310		

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02310	Continued From page 17 The findings include: R3's diagnoses included hemiplegia (paralysis of one side of the body) of dominant right side, diabetes type II (insufficient production of insulin, causing high blood sugar), and left buttock pressure ulcer (bed sore). R3's Care Communication Note dated December 19, 2022, included R3 had reported a small sore on his bottom. The note indicated the nurse was notified and came to assess the sore. R3's prescriber order dated December 19, 2022, instructed to cleanse buttocks wound gently bid (twice daily) and apply barrier cream bid until healed. R3's physician rounding form dated December 21, 2022, included a nursing concern: resident with 1 centimeter (cm) by 1 cm open sore on left buttock. Orders written by prescriber on same form included: please check to make sure he is getting the barrier cream twice daily and can use his wheelchair cushion in his recliner to try to help decrease pressure on buttocks. R3's medication administration record (MAR) dated January 2023, included: simple wound care, cleanse buttocks wound gently twice daily and apply barrier cream twice daily until healed. If wound worsens before showing symptoms of improvement notify nursing for sore on bottom. R3's Service Checkoff List dated January 2023, included: wound care, cleanse buttocks wound gently twice daily and apply barrier cream twice daily until healed. Wound care performed by unlicensed staff. Notify the nurse immediately if	02310		

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02310	Continued From page 18 the skin around the wound looks red, is warm, painful, discharge is coming out of the wound, or swelling. On January 31, 2023, at 9:05 a.m. unlicensed personnel (ULP)-H and ULP-G were observed to assist R3 in morning cares. ULP-H and ULP-G used a stand lift (a mechanical device used to help get resident to a standing position) to transfer R3 from his bed, brought him into the bathroom, and sat R3 on the toilet. After toileting R3, the stand lift was utilized to stand R3 up so wound care could be performed. ULP-G cleansed R3's buttocks with cleansing wipes and barrier cream was applied to R3's left inner buttock open area. ULP-G stated the area was open with white chaffed skin, but "looked better". R3's record lacked evidence the registered nurse (RN) completed monitoring or a reassessment of an open area to left inner buttock. On February 1, 2023, at 11:43 a.m., RN-J stated she had assessed the open area as soon as staff had notified her about it and obtained wound care orders from provider at that time. RN-J stated wounds should be measured and monitored at least weekly and stated R3's record lacked documentation of any follow up of the open area since wound was identified. On February 1, 2023, at 11:43 a.m., director of health service (DHS)-B verified R3's record lacked follow up of wound and indicated the area should have had on-going monitoring. The licensee's Wound Care-Dressing Change policy dated March 1, 2014, included: 10. Using the institution- approved assessment tool, assess key wound characteristics.	02310		

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02310	Continued From page 19 a. Anatomic location of the wound on the body. b. Extent of tissue loss. Determine if the wound is full or partial thickness. c. Color, type, and percentage of tissue, and whether it is granulation tissue, slough tissue, or eschar. d. Size of wound (length, width, and depth) in centimeters. e. Visible tunnels or undermining. Measure and document depth and direction. f. Exudate from the wound (amount, color, and consistency). g. Presence of odor. h. Periwound skin integrity (including color, texture, temperature, and description of any areas that are open, stripped, or have a rash. i. phase of wound healing, if the wound is a full-thickness wound. The licensee's policy lacked direction of how often reassessment of the wound would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/30/23*
Time: 11:00:52
Report: 1020231011

Food and Beverage Establishment Inspection Report

Location:
The Pillars Of Mankato
3125 Prairie Rose Drive
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0038393
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073446777
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

HIGH TEMP DISHWASHER USED AT THE ESTABLISHMENT. PROVIDE AN IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR SUCH AS A DISH TEMP, THERMOLABELS, OR A MIN/MAX THERMOMETER AND USE 2-3X WEEKLY TO ENSURE THE UTENSIL SURFACE TEMP REACHES 160F.

Comply By: 02/13/23

Surface and Equipment Sanitizers

Wash Temperature Gauge: = at 150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Final Rinse Temperature Ga: = at 210 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Utensil Surface Temperatur: = at 168 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: CHEESY POTATO SOUP - TABLE TOP HOT HOLDING UNIT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 175 Degrees Fahrenheit - Location: CHICKEN - STEAM TABLE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT TOMATO - TOP OF PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT WATERMELON - BOTTOM OF PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: PORK LOIN - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: EGG SALAD - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: COTTAGE CHEESE - UPRIGHT COOLER
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE.

SERVE BETWEEN 60-80 INDIVIDUALS FOR MEAL SERVICES.
DISCUSSED COOLING AND RE-HEATING PROCEDURES. ANY LEFT OVER FOOD ITEMS PREPARED ARE COOLED ACCORDING TO PROCEDURES OUTLINED IN THE MN FOOD CODE. FOOD RE-HEATED IS RE-HEATED TO A MINIMUM OF 165F AND ANY LEFTOVERS FROM RE-HEATED FOOD ITEMS ARE DISCARDED.

DISSCUSED MAJOR FOOD ALLERGENS AND PROCEDURE FOR RESIDENTS.

Type: Full
Date: *01/30/23*
Time: 11:00:52
Report: 1020231011
The Pillars Of Mankato

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020231011 of 01/30/23.

Certified Food Protection Manager: Jana Larson

Certification Number: FM17697 Expires: 02/03/24

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed:
Ashley B

651-201-4500

Report #: 1020231011

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	01/30/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:52
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
The Pillars Of Mankato	3125 Prairie Rose Drive	Mankato, MN	56001	5073446777

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038393		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 01/31/23

Inspector (Signature)