Electronically Delivered

January 22, 2026

Licensee
Heather Haus
223 4th Street Northwest
Blooming Prairie, MN 55917

RE: Project Number(s) SL30673016

Dear Licensee:

On January 13, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 23, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

November 7, 2025

Licensee
Heather Haus
223 4th Street Northwest
Blooming Prairie, MN 55917

RE: Project Number(s) SL30673016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30673	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

(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: SL30673016-0 On October 20, 2025, through October 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 19 residents; 19 receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on October 20, 2025, at a level 3/Widespread (I). The licensee took action on October 20, 2025; however, the scope and level remain at I. 1290: An immediate order was issued on October 22, 2025, at a level 3/Widespread (I). The licensee took action on October 22, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 510	Continued From page 1	0 510		
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 effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of two unlicensed personnel (ULP-E, ULP-F) during personal cares, medication administration, and blood sugar checks. 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:	0 510		

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0 510	Continued From page 2 ULP-E On October 21, 2025, at 6:50 a.m., the surveyor observed ULP-E provide R1's morning cares, don R1's compression stockings, and assisted R1 with getting dressed. ULP-E then transferred R1 to her wheelchair and assisted her to the bathroom. ULP-E donned clean gloves, changed R1's catheter bag from the overnight bag to a leg bag. ULP-E removed her gloves, washed her hands and donned clean gloves; however, ULP-E then assisted R1 to a standing position, washed R1's bottom after a bowel movement, pulled up her underwear, assisted to a seated position in her wheelchair, she used the same gloves to assist R1 with applying toothpaste to her toothbrush and handed the toothbrush to R1 to brush her teeth. ULP-E moved on to the task of emptying R1's overnight urine bag and rinsed it. ULP-E then removed her gloves and washed her hands. ULP-E failed to remove her soiled gloves and wash her hands after she assisted R1 with washing her bottom following toileting and before handling R1's toothpaste and toothbrush. ULP-F On October 21, 2025, at 7:40 a.m., the surveyor observed ULP-F complete R3's morning cares and donned R3's compression stockings. ULP-F then checked R3's blood sugar. ULP-F donned gloves, obtained a drop of blood from R3 and placed it on the blood sugar test strip. Following the blood sugar monitor read, ULP-F removed the test strip, gathered the blood testing supplies and returned to the medication cart and disposed of the used testing pieces. ULP-F then removed	0 510		

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0 510	Continued From page 3	0 510		

her gloves and without sanitizing her hands, unlocked the medication cart and placed R3's testing kit into the cart. ULP-F then documented R3's blood sugar results on the computer.
At 8:00 a.m., ULP-F set up R1's medications. ULP-F set up seven oral medications into a medication cup, and mixed R1's Metamucil into a separate cup. ULP-F went to R1's room, removed a set of gloves from the box and donned them. She then assisted R1 with medication administration by taking each pill one at a time and placing in R1's mouth. ULP-F assisted R1 with her glass of Metamucil, removed her gloves and disposed of the medication cup. Without sanitizing her hands, ULP-F returned to the medication cart and pushed it down the hallway outside of the next resident room, and ULP-F went to the kitchen to obtain a glass of orange juice for the next resident's medication administration.
At 8:09 a.m., ULP-F unlocked the medication cart and set up R4's medications. ULP-F entered R4's room, administered her medications and without sanitizing her hands, returned to the medication cart to dispose of medication supplies, charted R4's medication administration, and returned to the kitchen to obtain more orange juice for the next resident's medication administration.
At 8:20 a.m., ULP-F set up R5's medications, gathered blood pressure equipment and entered R5's room. ULP-F administered R5's medications, checked her blood pressure and checked R5's oxygen concentrator setting to ensure it was at 2 liters/minute flow. ULP-F then returned to the medication cart and without sanitizing her hands, returned equipment to the medication cart and documented medication administration and blood pressure results.
At 8:40 a.m., ULP-F set up R6's medications and

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0 510	Continued From page 4 entered R6's room and administered her medications. Following R6's medication administration, ULP-F returned to the medication cart, and without sanitizing her hands, documented medication administration on the computer. At 8:45 a.m., ULP-F set up R7's medications to include five oral medications, one insulin injection and gathered R7's blood sugar testing equipment. ULP-F entered R7's room, donned gloves and checked R7's blood sugar by obtaining a blood drop from a finger poke, placed the drop onto the test strip and noted the blood sugar monitor reading. ULP-F then removed the test strip from the monitor and disposed of it. ULP-F then removed her gloves and without sanitizing her hands, donned clean gloves and set up R7's insulin pen for injection. Following R7's insulin injection, ULP-F removed her gloves, gathered equipment and returned supplies to the medication cart. ULP-F then documented R7's medication administration and blood sugar results. ULP-F failed to sanitize her hands following glove use with blood sugar monitoring and following and between each observed resident contact with medication administration. On October 21, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated she expected staff to sanitize hands immediately following removal of gloves and in between resident contact. CNS-C further stated, "there are plenty of alcohol-based hand sanitizer units on the walls everywhere here." The licensee's Hand washing policy dated June 14, 2022, indicated handwashing is one of the	0 510		

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0 510	Continued From page 5 best ways to protect residents, yourself, and other staff from getting sick through spread of infection. Handwashing should be done at minimal: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client The licensee's Procedure for Using Gloves policy dated August 19, 2022, indicated Gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container biohazardous if they have contaminated material on them. Rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment	0 550		

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0 550	Continued From page 6 to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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). The findings include: On October 20, 2025, at 12:00 p.m. during the facility tour, the surveyor observed postings located in the foyer area and on a bulletin board close to the entrance of the facility. The bulletin board included a posting indicating the contact information for the regional Office of Ombudsman for Long-Term Care; however, the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities	0 550		

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0 550	Continued From page 7 was not found. Additionally, the facility's grievance procedure and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances was not noted. On October 20, 2025, at 12:55 p.m., house manager/licensed practical nurse (HM/LPN)-B stated the grievance forms were stored in the Emergency Preparedness binder housed just below the bulletin board. Upon review, the front of the binder held several blank grievance forms that HM/LPN-B indicated were available to residents or visitors; however, the grievance procedure including the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances was not included or posted as required. HM/LPN-B further stated she was not aware the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities was required. The licensee failed to post the required information about the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 8 (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 (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 R1 was admitted to the facility on March 29, 2021, with diagnoses to include dermatopolymyositis (condition in which swelling	0 630		

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0 630	Continued From page 9 and irritation, called inflammation, attacks the body's tissues, and causes muscle weakness and a skin rash), osteoarthritis, depression, and peripheral vascular disease. R1's Service Plan dated September 23, 2025, included the services of medication management/administration, assistance with dressing/grooming/dressing, toileting, catheter management, compression stockings, and mobility. On October 21, 2025, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-E don gloves, don R1's compression stockings, and assisted with morning cares, dressing, transferring and toileting. R1's IAPP dated September 23, 2025, included the following: A. Sexual Abuse- Is the person susceptible to abuse in this area? "No" was circled B. Physical Abuse-Is the person susceptible to abuse in this area? "No" was circled C. Self-Abuse-Is the person susceptible to abuse in this area? "No" was circled D. Financial Exploitation- Is the person susceptible to abuse in this area? "No" was circled. R3 R3 was admitted to the facility under the licensee's assisted living facility (ALF) license on October 2, 2025, with diagnoses including Type 2 diabetes, Parkinsonism, hypertension and polymyalgia rheumatica (a type of arthritis). R3's Service Plan dated October 16, 2025, included the services of medication	0 630		

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0 630	Continued From page 10 administration, blood sugar checks, compression stockings and assistance with toileting. On October 21. 2025, at 7:40 a.m., the surveyor observed ULP-F don R3's compression stockings, administer oral and topical medications and check her blood sugar. R3's IAPP dated October 16, 2025, included the following: A. Sexual Abuse- Is the person susceptible to abuse in this area? "No" was circled B. Physical Abuse-Is the person susceptible to abuse in this area? "No" was circled C. Self-Abuse-Is the person susceptible to abuse in this area? "No" was circled D. Financial Exploitation- Is the person susceptible to abuse in this area? "No" was circled. The licensee failed to indicate R1 and R3 were recognized as vulnerable adults receiving services and were susceptible to abuse (in various forms including neglect) by others, including other vulnerable adults and failed to implement interventions to minimize the risk of abuse. On October 23, 2025, at 1:50 p.m., clinical nurse supervisor (CNS)-C stated all residents were considered vulnerable adults. She further stated the previous registered nurse (RN) created the IAPP form now used and assumed it included the required verbiage. The licensee's Vulnerable Adult Maltreatment policy dated August 25, 2022, indicated [licensee name] will create an environment and process to identify, prevent and mitigate maltreatment of	0 630		

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0 630	Continued From page 11 vulnerable adults. Each resident will have an individual abuse prevention plan. An abuse prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services. The individual abuse prevention plan will include be based upon an individualized review or assessment of the resident's: - susceptibility to abuse by another individual, including other vulnerable adults - specific measures to be taken to minimize the risk of abuse, abuse to others and self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 12 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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-E started employment on April 17, 2023, to provide direct care services to the licensee's residents. On October 21, 2025, at 6:50 a.m., the surveyor observed ULP-E provide R1's morning cares, don R1's compression stockings, change R1's overnight catheter bag to her daytime leg bag and assisted R1 with getting dressed. ULP-E stated she had been trained and observed by the licensee's previous registered nurse (RN). ULP-E's employee record lacked evidence of	0 650		

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0 650	Continued From page 13 medication/treatment training and competency by the RN. Furthermore, her employee record lacked evidence of initial orientation training and competencies. On October 23, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated they had searched records and files and could not find ULP-E's orientation training/competency documents. House manager/licensed practical nurse (HM/LPN)-B stated the RN (prior to CNS-C) was observed to complete competencies and had observed ULP-E before ULP-E was independently working with residents. She further stated the RN was terminated from employment shortly after and either shredded or removed many documents from the facility and were not sure what may be missing. CNS-C stated she would "re-do" ULP-E's training/competency checklist to ensure it was in her record. The licensee's Personnel Records policy dated August 20, 2022, indicated the personnel record for each person will include: - record of all required training for unlicensed personnel and competency evaluations; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On October 20, 2025, from 1:00 p.m. to 3:30 p.m., the surveyor toured the facility with environmental services director (ESD)-D. During the tour, the surveyor observed: FIRE RATED DOORS: Resident rooms, at the facility had fire rated assemblies and rated fire doors. The doors and rated assemblies all show evidence that automatically closing mechanism had been removed. Swinging fire doors shall close from the full-open position and latch automatically. CARBON MONOXIDE ALARM: Facility didn't have carbon monoxide alarms in the resident rooms or carbon monoxide alarms connected to the monitored fire alarm panel at the source of fuel fired appliances. Mechanical rooms that have fuel fired appliances will be	0 775		

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0 775	Continued From page 15 equipped with a carbon monoxide detector connected to the fire alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State fire code. During a facility tour on October 20, 2025, at 2:30 p.m., ESD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 16 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, from 1:00 p.m. to 3:30 p.m., the surveyor toured the facility with environmental services director (ESD)-D. The following was observed. HOLES: In the bedroom of resident room E-2 there was a hole in the wall from old sprinkler work that was not closed. Holes can reduce the fire separation allowing the spread of fire. On October 20, 2025, at 2:30 p.m., ESD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 17 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. 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	0 810		

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0 810	Continued From page 18 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 potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, from 1:00 p.m. to 2:30 p.m., with environmental services director (ESD)-D. Surveyor asked for the documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Emergency Plan Heather Haus", March 18, 2022, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Facility has resident actions in a handbook that they receive upon move in. ESD-D stated they will add those procedures to the FSEP.	0 810		

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0 810	Continued From page 19 UNIQUE AND UNUSUAL RESIDENT NEEDS: Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. ESD-D stated the facility is moving to an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use care plan website or what to do in the loss of power/internet event was not it a staff action to evacuate with binder containing resident information for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On October 20, 2025, at 2:30 p.m., ESD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility could only provide documentation for one staff training on October 15, 2025. Facility documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation.	0 810		

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0 810	Continued From page 20 On October 20, 2025, at 2:30 p.m., ESD-D stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 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	01060		

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01060	Continued From page 21 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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R8). 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: R8 was admitted to the facilty on March 21, 2016, with diagnoses including congestive heart failure with oxygen dependence, and chronic	01060		

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01060	Continued From page 22 kidney disease. R8's Service Plan dated September 17, 2025, indicated she received services including assistance with transfers, bathing, dressing, grooming and medication administration. R8's progress notes included an entry on September 28, 2025, indicating R8 had been transported to the hospital and admitted for a likely infection. No further documentation was noted; however, R8 had not returned to the facility. R8's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date 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; - 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. In addition, R8's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On October 21, 2025, at 11:05 a.m., clinical	01060		

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01060	Continued From page 23 nurse supervisor (CNS)-C stated she was not aware of the requirements regarding a resident's emergency relocation and the need to notify the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD TO CORRECT: 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 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 current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for four of 19 employees	01290		

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01290	Continued From page 24 (unlicensed personnel (ULP)-G, ULP-H, ULP-F and clinical nurse supervisor (CNS-C). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on October 22, 2025. 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 October 22, 2025, at 7:00 a.m., the surveyor reviewed the licensee's current employee roster and the NETStudy roster dated October 20, 2025. The licensee is currently licensed as an Assisted Living Facility (ALF) with health facility identification (HFID) number 30673. CURRENT BACKGROUND STUDY ULP-G ULP-G was hired on June 8, 2021, to provide direct care services for the licensee's residents. NETStudy Roster dated October 22, 2025, indicated ULP-G had a previous background study completed/dated June 2, 2021, with HFID number 27084 (not the licensee's current HFID). The NETStudy roster further indicated a separation date of March 30, 2022.	01290		

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01290	Continued From page 25 On October 22, 2025, at 11:10 a.m., office assistant (OA)-J stated she was uncertain about why ULP-G was not appearing on the current NETStudy roster and would need to look into it further. On October 22, 2025, at 11:43 a.m., OA-J provided a copy of ULP-G's background study dated June 2, 2021, with affiliation to HFID 27084. OA-J stated she assumed HFID 27084 was associated with the licensee's previous comprehensive license. OA-J further stated she could not recall ULP-G separating employment and was not sure why NETStudy indicated there was separation on March 30, 2022. On October 22, 2025, at 12:03 p.m., house manager/licensed practical nurse (HM/LPN)-B stated ULP-G was an on-call staff for the licensee, had not worked since the summer, but had worked without direct supervision. The licensee failed to ensure ULP-G had a current and eligible background study. ULP-H ULP-H had a hire date of April 18, 2017, to provide direct care services for the licensee's residents. NETStudy Roster dated October 22, 2025, indicated ULP-H had a previous background study completed/dated January 17, 2017, with HFID number 27084 (not the licensee's current HFID). The NETStudy roster further indicated a separation date of March 30, 2022. On October 22, 2025, at 11:10 a.m., OA-J stated	01290		

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01290	Continued From page 26 she was uncertain about why ULP-H was not appearing on the current NETStudy roster and would need to look into it further. On October 22, 2025, at 11:43 a.m., OA-J provided a copy of ULP-H's background study dated January 27, 2017, with affiliation to HFID 27084. OA-J stated she assumed HFID 27084 was associated with the licensee's previous comprehensive license. OA-J further stated she could not recall ULP-H separating employment and was not sure why NETStudy indicated there was separation on March 30, 2022. On October 22, 2025, at 12:03 p.m., HM/LPN-B stated ULP-H was an on-call staff for the licensee, had not worked since the summer, but had worked without direct supervision. The licensee failed to ensure ULP-H had a current and eligible background study. AFFILIATION ULP-F ULP-F had a hire dated of April 1, 2021, to provide direct care services for the licensee's residents. On October 22, 2025, at 10:30 a.m., HM/LPN-B provided the surveyor with a paper copy of ULP-F's background study dated April 16, 2022, which indicated affiliation to HFID 650, which is the skilled nursing facility (SNF) attached to the licensee. On October 22, 2025, at 11:00 a.m., HM/LPN-B stated ULP-H was an active employee and had worked without direct supervision.	01290		

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01290	Continued From page 27 On October 22, 2025, at 11:10 a.m., OA-J stated she did not know how to affiliate background studies between both licenses (each with their own HFID number). The licensee failed to ensure ULP-F's background clearance was affiliated with this licensee's HFID number 30673. CNS-C CNS-C's record included a registered nurse (RN) license issued by the Minnesota Board of Nursing effective August 21, 2013, with an expiration date of May 31, 2027. On October 22, 2025, at 10:30 a.m., CNS-C provided the surveyor with a paper copy of her background study dated April 21, 2023, and indicated affiliation to HFID 650 (SNF). CNS-C stated she had worked between both licenses for some time, but primarily worked at the licensee's assisted living facility (HFID-30673) for the past couple of weeks and did not have direct supervision at all times while working with the ALF residents. On October 22, 2025, at 11:10 a.m., OA-J stated she did not know how to affiliate background studies between both licenses (each with their own HFID number). The licensee failed to ensure CNS-C's background clearance was affiliated with the facility's HFID number 30673. The licensee's Screening of Job Applicants dated August 24, 2022, indicated all job applicants will be screened to assure compliance with	01290		

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01290	Continued From page 28 applicable state laws and [facility name] Assisted Living requirements, including background checks and screening for TB. No new employee will have unsupervised direct contact with residents until all required screenings have been satisfactorily completed and any applicable licenses, registrations or certifications have been verified. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on October 22, 2025; however, the scope and level remain at I.	01290		
01750 SS=F	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 specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for one of one resident (R1) for medication	01750		

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01750	Continued From page 29 administration delegated to unlicensed personnel. 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 was admitted to the facility on March 29, 2021, with diagnoses to include dermatopolymyositis (condition in which swelling and irritation, called inflammation, attacks the body's tissues, and causes muscle weakness and a skin rash), osteoarthritis, depression, and peripheral vascular disease. R1's Service Plan dated September 23, 2025, included the service of medication management/administration. On October 21, 2025, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-E don gloves, don R1's compression stockings, and assist with morning cares, dressing, transferring and toileting. R1's signed, provider's orders dated September 16, 2025, September 22, 2025, September 26, 2025, October 3, 2025, and October 16, 2025, indicated the following scheduled medications: one for cough, one for depression, one topical hormonal replacement, one for heart/kidney	01750		

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01750	Continued From page 30 disease (fluid retention), one for dermatopolymyositis, one for thyroid, one for blood pressure, one for sleep, one for heart rate/blood pressure control, one for acid reflux, one steroid/anti-inflammatory, two for constipation, one for mild pain, and one eye drop for dry eyes. Additionally, R1's orders included the following as needed (PRN) medications; one inhaler for wheezing/shortness of breath, one eye drop for dry eyes, one oral medication for mild pain, one for severe pain/shortness of breath, one for constipation, one for excessive secretions, one for diarrhea, one for anxiety, one for constipation, three for cough, one for nausea/vomiting, one topical cream for itching skin, one rectal suppository for constipation and one topical powder for rash. R1's medication administration record (MAR) dated October 2025, included: -benzonatate 100 milligram (mg) capsules give one capsule every eight hours as needed for cough -Mucinex Dextromethorphan (DM) 20-400 mg/20 milliliters (ml) give 10 ml every six hours as needed for cough -Tussin DM 10-200 mg/5 ml, give 5 ml every six hours as needed for cough -bisacodyl suppository, insert one rectal suppository every 24 hours as needed for constipation -polyethylene glycol 1450 powder, give 17 grams (gm) orally as needed for constipation The licensee failed to provide written instruction for the ULP to understand which PRN medication for cough and constipation should be used first and second/third.	01750		

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01750	Continued From page 31 On October 23, 2025, at 1:50 p.m., clinical nurse supervisor (CNS)-C stated she was not aware there was a need to specify in writing, instructions for the ULP to follow when multiple PRN medications for the same symptoms were being prescribed. The licensee's Medication Management Services policy dated May 26, 2022, indicated when administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has specified in writing, specific instructions for each resident and documentation in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	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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01760	Continued From page 32 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 ordered for two of seven residents (R3, R4). 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: R3 R3 was admitted to the facility under the licensee's Assisted Living Facility (ALF) license on October 2, 2025, with diagnoses including Type 2 diabetes, Parkinsonism, hypertension and polymyalgia rheumatica (a type of arthritis). R3's Service Plan dated October 16, 2025, included the service of medication management/administration. On October 21, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-F don R3's compression stockings, administer oral and topical medications and check her blood sugar. When ULP-F administered R3's diclofenac gel (a topical pain medication), the surveyor observed her to squeeze an undetermined amount on her gloved finger and massage into both knees and both wrists. ULP-F stated she "kind of guessed"	01760		

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01760	Continued From page 33 how much was needed. R3's medication administration record (MAR) dated October 2025, indicated she received two oral medications for hypertension, one for blood thinning, two for type 2 diabetes, one for Parkinson's symptoms, one for mild pain, one for arthritis/nerve pain, one for sleep, one for cholesterol, three supplements, one eye drop for glaucoma, one eye drop for dry eyes, one type 2 diabetes injection, one topical cream for skin rash, and one topical pain medication. R3's signed prescriber's orders dated September 24, 2025, indicated diclofenac 1% gel, apply 2 grams (gm) topically four times daily. Apply to bilateral wrists. Maximum dose 32 gm/day and 16 gm/joint/day. The licensee failed to ensure R3 received the proper dose of diclofenac gel and failed to utilize the proper measuring tool (available in the diclofenac box). On October 21, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-C stated the ULP have been trained to use the proper measuring tool and were expected not to approximate. R4 R4 was admitted to the facility on October 1, 2012, with diagnoses including paranoid schizophrenia, arthritis, and polyosteoarthritis. R4's Service Plan dated October 1, 2025, included the service of medication administration. On October 21, 2025, at 8:09 a.m. the surveyor observed ULP-F to pour an undetermined	01760		

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01760	Continued From page 34 amount of Metamucil (for constipation) into a glass of orange juice. ULP-F then stopped and stated, "Oh, I should have measured it. You said to do things as I normally do, so this is how I have done it." R4's MAR dated October 2025, indicated R4 received one oral medication for pain, one for thyroid, three for constipation, one for acid reflux, one for paranoid schizophrenia, two for arthritis pain, one supplement, one eye drop for macular cyst (cyst in eye), one injection for schizophrenia, one nebulizer for shortness of breath, two skin creams for rash, and one topical pain medication. R4's signed prescriber's orders dated November 13, 2024, indicated Metamucil 3.4 gm, mix one packet in liquid and drink daily. (3.4 gram is equivalent to 1 teaspoon) The licensee failed to ensure R4 received the proper dosing of Metamucil as ordered. On October 21, 2025, at 11:20 a.m., CNS-C stated she expected the ULP to measure medications accurately. The licensee's Administration of Medication, Treatment and Therapy by unlicensed Personnel policy dated January 1, 2015, indicated medications, treatment and therapy always need to be administered according to the "6 Rights" including: a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops,	01760		

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01760	Continued From page 35 etc.) f. Right chart/record to document that the medication, treatment and therapy was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01770 SS=F	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 review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (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 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 October 20, 2025, at 11:30 a.m., house manager/licensed	01770		

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01770	Continued From page 36 practical nurse (HM/LPN)-B stated the licensee provided medication management services to their residents, including medication setup. HM/LPN-B stated she set up medications in medication boxes for a couple residents who self-administered their own medications; however, HM/LPN-B did not document the medication set up. R10's Service Plan dated August 15, 2025, included the service of weekly medication set up by the nurse. R10's MAR dated October 2025, indicated the following medications were set up by the licensee: - aspirin 81, milligrams (mg), one tablet given orally daily for heart management; - atorvastatin 20 mg, one tablet orally daily for cholesterol; - losartan potassium 50 mg, give one tablet daily by mouth for hypertension and kidney disease; - sennoside-docusate sodium 8.6-50 mg, give one tablet by mouth daily for constipation; - furosemide 20 mg, give one tablet orally every 48 hours for chronic kidney disease/water retention On October 23, 2025, at 11:00 a.m., HM/LPN-B provided the surveyor with R10's medication administration record (MAR) dated October 2025. The MAR included a handwritten notes in each medication space as entered by HM/LPN-B on October 23, 2025, (during the survey). HM/LPN-B stated she wrote on the printed MAR for the surveyor to understand which medications were set up by her on a weekly basis, and which medications were kept by R10 in her own apartment. HM/LPN-B further stated she did not	01770		

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01770	Continued From page 37 document her weekly medication set up for R10 nor other residents, as she was not aware of the requirement. On October 23, 2025, at 1:15 p.m., HM/LPN-B provided the surveyor with R10's Monday through Sunday medication pill box which included several pills in each day's section. The licensee's Medication Management Services policy dated May 26, 2022, indicated: 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 time of setup No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident	01950		

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01950	Continued From page 38 and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of two residents (R3, R7) with blood sugar monitoring, two of two residents (R3, R7) with compression stockings and one of one resident (R1) with Foley urinary catheter. 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: BLOOD SUGAR MONITORING R3 R3 was admitted to the facility under the licensee's assisted living facility (ALF) license on October 2, 2025, with diagnoses including Type 2 diabetes, Parkinsonism, hypertension and polymyalgia rheumatica (a type of arthritis). R3's Service Plan dated October 16, 2025,	01950		

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	30673	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

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01950	Continued From page 39 included the service of medication management/administration. On October 21, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-F administer oral and topical medications and check her blood sugar. Following completion of the treatments and medication administration, ULP-F documented the medication administration and blood sugar level on R3's electronic medical record (EMR). No parameters for R3's blood sugar readings were noted. R3's Blood Sugar documentation record dated October 2025, indicated blood sugars were checked twice daily related to type 2 diabetes. R3's signed prescriber's orders dated September 24, 2025, indicated blood sugar checks twice daily and as needed. R3's record lacked individualized instructions for what ULP should monitor for related to blood sugar levels and when to notify nursing. R7 R7 as admitted on August 31, 2023, with diagnoses including unspecified dementia, type 2 diabetes, and hypertensive kidney disease. R7's Service Plan dated July 29, 2025, included the services of blood sugar monitoring three times daily and assistance with compression stockings daily. On October 21, 2025, at 8:45 a.m., the surveyor observed ULP-F to check R7's blood sugar and administer medications.	01950		

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HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

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01950	Continued From page 40 R7's Blood Sugar documentation dated October 2025, indicated check blood sugar before meals, three times a day related to type 2 diabetes. R7's signed prescriber's orders dated November 20, 2024, indicated monitor blood sugars three times daily. R7's record lacked individualized written instructions for what ULP should monitor for related to blood sugar levels and when to notify nursing. COMPRESSION STOCKINGS R3 On October 21, 2025, at 7:40 a.m., the surveyor observed ULP-F don R3's compression stockings R3's signed prescriber's orders dated September 24, 2025, indicated compression garment, knee high compression stockings on in the morning and off at bedtime. R3's Task documentation dated October 2025, indicated to apply thrombo-embolic-deterrent (TED) hose in the morning and remove before bedtime. R3's record lacked individualized instructions for what ULP should monitor for (redness, open skin) when using compression stockings. R7 On October 21, 2025, at 8:45 a.m., the surveyor observed ULP-F to administer medications, check R7's blood sugar and administer insulin	01950		

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01950	Continued From page 41 injection. The surveyor observed R7 wearing compression stockings. R7 stated another staff had helped her get them on earlier. R7's signed prescriber's orders dated March 25, 2025, indicated wear TEDS daily off at 9:00 p.m.-ok to use Velcro wraps if easier and better tolerated. R7's Task documentation record for October 2025, was requested but not received. R7's record lacked individualized instructions for what ULP should monitor for (redness, open skin) when using compression stockings. FOLEY CATHETER R1 R1 was admitted to the facility on March 29, 2021, with diagnoses to include dermatopolymyositis (condition in which swelling and irritation, called inflammation, attacks the body's tissues, and causes muscle weakness and a skin rash), osteoarthritis, depression, and peripheral vascular disease. R1's Service Plan dated September 23, 2025, included the service of hospice and Foley urinary catheter management. On October 21, 2025, at 6:45 a.m., the surveyor observed ULP-E don gloves, don R1's compression stockings, and assisted with morning cares, dressing, transferring and changing R1's overnight urinary bag to a daytime leg bag and cleansing the overnight bag for reuse.	01950		

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01950	Continued From page 42 R1's signed prescriber's orders dated September 26, 2025, indicated Foley catheter 16 French with 10 milliliter (ml) balloon, change every 21 days and as needed. R1's Task documentation record dated October 2025, included change Foley bag from night bag to day bag, empty Foley overnight bag, document urinary output, and change Foley bag from day bag to night bag. R1's record lacked individualized instructions for what ULP should monitor for (cloudy, foul smell, blood or low urine output) and when to contact nursing. On October 23, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-C stated she was not aware of the requirement to include written instructions for the ULP to reference with delegated treatments. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated January 1, 2015, indicated treatments or therapy tasks may be delegated or assigned by a Licensed Health Professional to unlicensed personnel according to the Licensed Health Professional's applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the registered nurse (RN) or authorized Licensed Health Professional must develop written specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for the licensee's two residents (R1, R2) who both had bed rails. This resulted in an immediate correction order on October 20, 2025. 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 October 20, 2025, at 11:30 a.m., housing manager/licensed practical nurse (HM/LPN)-B and clinical nurse supervisor (CNS)-C stated they were not aware of the requirements for bedrail systems (hospital bed or consumer bed rail systems) for assisted living residents. HM/LPN-B and CNS-C stated they were aware of two residents living in the facility with bed rail systems.	02310		

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02310	Continued From page 44 R1 R1's diagnoses included dermatopolymyositis (condition in which swelling and irritation, called inflammation, attacks the body's tissues, and causes muscle weakness and a skin rash), osteoarthritis, depression, and peripheral vascular disease. R1's Service Plan dated September 23, 2025, included the services of medication management/administration, assistance with dressing/grooming/dressing, toileting, catheter management, compression stockings, and mobility. On October 20, 2025, at 12:45 p.m. during the facility tour, the surveyor noted R1's room to include a hospital bed with bilateral bedrails in the upright position that were securely fastened to the bed. HM/LPN-B and CNS-C stated the hospital bed was donated to the facility and R1 used the bedrails to assist with getting in and out of bed and to reposition while in bed. R1's record included a comprehensive assessment dated September 25, 2025, indicating R1 was a "heavy" assist for ambulation, and used a walker or wheelchair for mobility. R1's record lacked evidence the registered nurse (RN) completed an assessment of R1's use of her hospital bedrail system. R1's record did not include an assessment of her hospital bed rail, measurements of zones 1-4, nor education on the risks and benefits of bed rail use, as required.	02310		

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02310	Continued From page 45 R2 R2's diagnoses included stroke, compression fracture of vertebra, and atrial fibrillation. R2's Service Plan dated September 2, 2025, included the services of medication administration, assisting with dressing, and housekeeping. On October 20, 2025, at 12:45 p.m. during the facility tour, the surveyor noted R2's room included a standard bed with a consumer type bedrail on the right side of the bed. The consumer bedrail included two legs extending to the floor and included suction cup bases on the bottom of each leg. The legs attached to a "U" shaped bar that slipped between the mattress and box spring/lower mattress support. The bedrail was not securely fastened to the bed and the leg bases were sitting on carpeted flooring (not allowing the suction cupped ends to secure). HM-B and CNS-C stated the bedrail was brought to R2 and set up by R2's niece. R2 used the bedrail to assist with transfers from a sitting to a standing position when getting out of bed. R2's record included a comprehensive assessment dated September 2, 2025, which indicated R2 used a walker for ambulation; however the assessment lacked evidence the RN had assessed R2's hospital bedrail system. R2's record did not include an assessment of her consumer rail, education on the risks and benefits of rail use, manufacturer's instructions, and evidence of safety recall checks, as required. On October 20, 2025, at 2:30 p.m., CNS-C stated the electronic medical record system (EMR) did	02310		

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02310	Continued From page 46 not include a bed rail assessment. She was able to obtain an assessment tool and information for the risks verses benefits of bed rails from the nursing home connected to the assisted living facility (ALF). CNS-C stated bedrail assessments, risks verses benefits of bed rail use, and measurements of R1's hospital bedrails were not completed, and she was trying to locate the kind/manufacturer of R2's consumer bedrail system for instructions and any possible recall information which were not in R2's record. The licensee's Assessing the Safety of Side Rails Policy dated August 24, 2016, indicated staff will alert the RN if a client has any type of side rail or similar equipment and the RN will then evaluate whether the side rail appears to be safe for the client. The RN will educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side rail does not appear to meet FDA standards, the RN will recommend to the client, the client's representative, the client's involved family members that the side rail be removed and will recommend alternative options to reduce the risk of a fall out of bed. The RN will document these conversations and recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	02310		

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02310	Continued From page 47 the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail	02310		

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02310	Continued From page 48 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took action on October 20, 2025; however, the scope and level remain at I.	02310		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Heather Haus
223 4th Street NW
Blooming Prairie, MN 55917
Steele County
Parcel:

Phone:
cthurmes@prairiemanorinc.com

License Info

License: HFID 30673

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

Inspection Info

Report Number: F8044251237
Inspection Type: Full - Single
Date: 10/21/2025 Time: 8:24:57 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.13 *Priority Level: Priority 2 CFP#: 51*
MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.
COMMENT: Water filter for coffee maker dated 3/23 (filters should be changed every year).
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F8044251237 from 10/21/2025

Dayoni

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us