DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 15, 2025

Licensee
Nagel Assisted Living
232 Elm Street South
Waconia, MN 55387

RE: Project Number(s) SL31214016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 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.

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

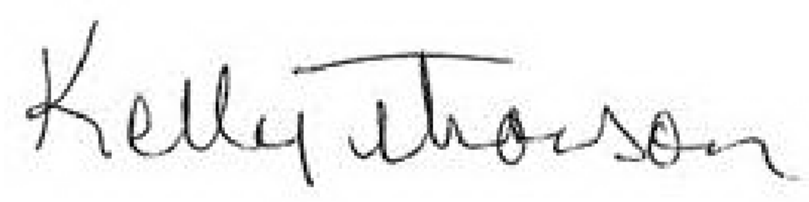
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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,



Kelly Thorson , Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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#31214016 On June 23, 2025, through June 25, 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 45 residents; 45 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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

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0 680	Continued From page 2 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: On March 23, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided licensee's emergency preparedness plan dated August 1, 2021. The licensee's EPP plan lacked evidence of the following required content: - missing resident quarterly review On June 25, 2025, at 10:30 a.m., LALD/CNS-A stated they had not reviewed the missing resident policy quarterly and were not aware of this requirement. The licensee's Missing Resident policy dated August 1, 2021, indicated [the facility] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to	0 700		

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0 700	Continued From page 3 control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 June 24, 2025, at 11:17 a.m., the surveyor observed a laptop on the assisted living medication cart, located at the main entrance of the facility, with R6's medication records visible. In addition, the narcotic count logbook was unsecured on the top of the medication cart. On June 24, 2025, at 11:23 a.m., unlicensed personnel (ULP)-I stated she walked away from the medication cart to obtain something behind the nursing desk. She stated she had been trained to close the electronic medical record (EMR) when she was not at the medication cart. On June 24, 2025, at 11:25 a.m., ULP-I stated the narcotic count logbook is always left on the top of the medication cart because they did not have	0 700		

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0 700	Continued From page 4 room to store it in the locked medication cart. On June 25, 2025, at 10:21 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that ULP's were trained to log out of the EMR and close the laptop when not at the medication cart. In addition, LALD/CNS-A stated that the narcotic count logbook is to be stored in the locked medication cart. The licensee's Confidentiality and HIPAA policy dated April 1, 2024, indicated to close and lock computer screens, do not leave care sheets or other resident identifying papers laying out and ensure resident information is only given to those that the resident has given permission to receive health information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota 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	0 775		

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0 775	Continued From page 5 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 June 24, 2025, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with housing director (HD)-H and maintenance manager (MM)-G. The surveyor made the following observations of non-compliance with current Minnesota State Fire Code (MSFC) provisions: FIRE RESISTANT RATED DOORS Fire-resistant rated doors at the following locations were provided with kick down door hold open devises that prevented the doors from closing automatically. - Apartments 118, 119, 120 - Health services office - Sunflower Court Dining & Activity Room - Med room/storage closet inside Sunflower Court Dining - Garden Terrace Dining & Community Room - Stairwell adjacent to apartment 211 - Storage access from stairwell adjacent to apartment 211 - Exit access door adjacent to apartment 207 Fire-resistant rated doors at the following locations did not close and latch. - Sunflower Court Dining & Activity Room Fire resistant rated doors are required to automatically close and latch to prevent the	0 775		

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0 775	Continued From page 6 spread of flame and smoke in the event of a fire or similar emergency. PATH OF EGRESS There were wheelchairs, mats, bed frames, and other miscellaneous items stored under the stairs and against the wall in the exit stairwell located adjacent to apartment 209. The stored materials reduced the exit stair width at the bottom by approximately 50%. Obstructions shall not be placed in the minimum width or required capacity of a means of egress component. The minimum width or required capacity of a means of egress system shall not be diminished along the path of egress travel. There were wheelchairs stored on the upper landing of the exit stairwell adjacent to apartment 123. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. FIRE ALARM AND FIRE SPRINKLER SYSTEM MAINTENANCE The sprinkler head in the storage room adjacent to the welcome center had a plastic, orange protection frame installed that would obstruct the proper function of the sprinkler head. The fire alarm and sprinkler system inspection report was dated November 17, 2023. HD-H and MM-G stated they did not have any other records of the system inspections. Water based automatic sprinkler systems are required to be inspected, tested, and maintained in accordance with MSFC Section 901 and National Fire Protection Association (NFPA) 25.	0 775		

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0 775	Continued From page 7 Fire alarm and detection systems are required to be inspected, tested, and maintained in accordance with MSFC Section 907 and National Fire Protection Association (NFPA) 72. These deficient conditions were visually verified by HD-H and MM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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; (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.	0 810		

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0 810	Continued From page 8 (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, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 4, 2024, housing director (HD)-H and maintenance manager (MM)-G provided 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, 9.06 Fire Policy, dated August 1, 2021; 9.07 Fire Safety, Evacuation Plan, Fire drills, dated August 1, 2021; Fire Emergency, undated; and 2.1 In Case of Fire,	0 810		

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0 810	Continued From page 9 dated March, 27, 2017, from the resident handbook, failed to include the following: The licensee failed to develop and maintain their FSEP. The licensee provided multiple policies for the surveyor to review, none of the policies reviewed met all the requirements for the FSEP listed in statute. Each policy had a different, partial version of each requirement. The FSEP 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) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. HD-H provided three pages from the resident handbook that included a section titled "2.1 In Case of Fire", dated March, 27, 2017, which had instructions for tenants to follow, but was not included in the complete FSEP. On June 24, 2025, at 2:30 p.m. HD-H and MM-G stated the corporate office develops the FSEP and they would work on improving the completeness and organization of their FSEP. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. HD-H and MM-G lacked documentation showing any training was offered or training was scheduled for	0 810		

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0 810	Continued From page 10 a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. HD-H and MM-G lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On June 24, 2025, at 2:30 p.m., HD-H and MM-G stated they use a video for basic fire training, but it was not specific to the licensee's FSEP. They also stated their was an in-person fire safety and evacuation training in 2024, but they could not find the documentation for it. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Checklist and Sign-In Sheet", undated, indicated evacuation drills were conducted on May 8, 2025, April 14, 2025, March 14, 2025, January 14, 2025, November 19, 2024, October 1, 2024, September 26, 2024, April 22, 2024, August 24, 2023, and July 25, 2023. No other documentation was provided. On June 24, 2025, at 2:30 p.m., HD-H and MM-G stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 910	Continued From page 11	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2's Master Assisted Living Resident Agreement (identified as the contract) was signed by R2 on February 6, 2023. R3's Master Assisted Living Resident Agreement (identified as the contract) was signed by R3 on	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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
0 910	Continued From page 12 December 13, 2022. R2 and R3's contract did not include the health facility identification (HFID) of the facility. On June 25, 2025, at 10:24 a.m., housing director (HD)-H stated he was not aware that the HFID was required on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for two of two residents (R2, R3). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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
0 970	Continued From page 13 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 and R3's Master Assisted Living Resident Agreement (identified as the contract) dated February 6, 2023, and December 13, 2022, included the following clause: -Page 20, section 30 of the contract indicated: Indemnification. As an occupant of the Facility, Resident assumes the risk for Resident's own safety and for the safety of Resident's personal property, guests and agents. Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with the loss of life, personal injury or damage to property, arising from or out of the use by Resident or Resident's guests of the Living Space or any other part of Facility, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. On June 25, 2025, at 10:25 a.m., housing director (HD)-H stated he was not aware that a waiver of liability could not be included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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
01910	Continued From page 14 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 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 to document in the resident's record all required content for disposition of medications for two of two residents (R1, R5) upon discharge. 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:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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
01910	Continued From page 15 During the entrance conference on June 23, 2025, at 11:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. R1 The licensee's Discharged or Deceased Resident Roster indicated R1 was admitted to the facility on May 27, 2025, and discharged on June 11, 2025. R1's Medication Disposition record lacked documentation of the prescription number for two of eight medications listed, gabapentin 300 milligram (mg), and Oxycodone 10 mg. R5 The licensee's Discharged or Deceased Resident Roster indicated R1 was admitted to the facility on October 16, 2024, and discharged on April 28, 2025. On June 24, 2025, at 12:15 p.m., surveyor observed the memory care unit medication fridge and found three (3) boxes of R5's insulin pens: -aspart 100u/milliliters (ml), 4 unopened pens -glargine-yfgn 100u/ml, 5 unopened pens -Lantus 100u/ml, 4 unopened pens The licensee failed to dispose of the medications and document all required content for disposition. On June 25, 2025, at 10:16 a.m., registered nurse (RN)-B stated she had begun to fill out the medication disposition form for R1 and had intentionally left the prescription number and the quantity for two of the medications blank in the	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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NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

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01910	Continued From page 16 event R1 required an additional as needed medication (PRN) prior to departure. RN-A stated she forgot to update the form at time of discharge but was aware of the medication disposition requirements. On June 25, 2024, at 10:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was unaware that R5's insulin remained in the memory care medication fridge. She stated they were aware of medication disposition requirements, and it must have been overlooked. The licensee's Medications Disposal policy dated August 1, 2021, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medications 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. Any current medications being managed by [the facility] must be provided to the resident when the resident's service plan ends. [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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

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NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

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02040	Continued From page 17 An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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 potential to affect a large portion or all of the residents). Findings include: On June 24, 2025, housing director (HD)-H and maintenance manager (MM)-G provided	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 18 documents on the hazard vulnerability assessment (HVA). The licensee's HVA, titled All Hazards Vulnerability Assessment - Community and All Hazards Vulnerability Assessment - Sunflower Communities, undated, failed to include the following: The HVA included the identification of global risk factors like severe weather, wild fires, epidemics, systems failures, and civil disturbances but failed to identify any potential hazards or risks that were specific to the facility's neighborhood, grounds, building, or population. The HVA did not include a section that identified specific mitigation factors to be in place for any hazards or risks that were identified in the HVA. On June 24, 2025, at 2:30 p.m. HD-H and MM-G stated they had not performed a hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 19 shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care. This practice resulted in a level one violation (a	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

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02110	Continued From page 20 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license effective through May 31, 2026, and was licensed for a bed capacity of 55 residents. On June 25, at 10:23 a.m., housing director (HD)-H stated they provide a five (5) page document, at time of admission, that is specific to dementia care. HD-H stated he was not aware that they needed to provide the specific policies, and they had not provided them to any resident and/or the resident's legal and designated representative. The licensee's Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2021, indicated these policies and procedures must be provided to residents and the residents' legal and designated representative at the time of move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	06/25/2025

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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Nagel Assisted Living
232 Elm Street South
Waconia, MN 55387
Carver County
Parcel:

Phone:

License Info

License: HFID 1214

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

Inspection Info

Report Number: F8087251048
Inspection Type: Full - Single
Date: 6/24/2025 Time: 12:30:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER STEVEN JEROME MILLER.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND ASSIGNED NURSE SURVEYOR.

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 Metro District Office inspection report number F8087251048 from 6/24/2025

John Boettcher

STEVEN JEROME MILLER
KITCHEN MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Nagel Assisted Living
Waconia
County/Group: Carver County

Inspection Info

Report Number: F8087251048
Inspection Type: Full
Date: 6/24/2025
Time: 12:30:00 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: JUICE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 12 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 45 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 42 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Reach-in Undercounter Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT LEAFY GREENS**; Temperature Process:** Cold-Holding
Location: Reach-in Undercounter Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
Location: Reach-in Undercounter Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Reach-in Undercounter Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 5 Degrees F.
Comment: STORAGE FREEZER - LEFT
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 12 Degrees F.
Comment: STORAGE FREEZER - RIGHT
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 35 Degrees F.
Comment: STORAGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: STORAGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: STORAGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** GROUND BEEF**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment: STORAGE
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Nagel Assisted Living
Waconia
County/Group: Carver County

Inspection Info

Report Number: F8087251048
Inspection Type: Full
Date: 6/24/2025
Time: 12:30:00 PM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 100 PPM
Comment:
Violation Issued?: No