Electronically Delivered

October 14, 2026

Licensee
Cedar Lodge
195 24th Place Northwest
Owatonna, MN 55060

RE: Project Number(s) SL30519016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 16, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 $1,000.00**. 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.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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: SL30519016-0 On September 14, 2026, through September 16, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 51 residents; 51 receiving services under the Assisted Living Facility 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of four residents (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) 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:	0 630		

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0 630	Continued From page 4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include activity assist, meal reminders, weight checks, blood pressure checks, blood sugar checks, and medication administration. R4's IAPP dated August 6, 2026, did not include the following: - a review or assessment of the resident's susceptibility to abuse by other individuals, including other vulnerable adults On September 16, 2026, at 10:00 a.m., director of quality (DQ)-G reviewed R4's IAPP and stated it did not include a review or assessment of R4's susceptibility to abuse by other individuals, including other vulnerable adults. The licensee's Individual Abuse Prevention Plan policy dated September 1, 2026, indicated an individual abuse prevention plan was developed for each assisted living resident. The individual abuse prevention plan would include: -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults -the resident's risk of abusing other vulnerable adults -specific measures to minimize the risk of abuse to that person and other vulnerable adults -measure to minimize the risk of self-abuse if applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 5 days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 810	Continued From page 6	0 810		
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. (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	0 810		

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0 810	Continued From page 7 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 8 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for four of four residents (R1, R2, R3, and R4). 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:	0 950		

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0 950	Continued From page 9 R1 R1 was admitted on June 7, 2024, with diagnoses that included diabetes. R1's Resident Agreement dated February 17, 2025, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. R2's Resident Agreement dated January 8, 2025, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R2's record lacked evidence in writing of providing on a document separate from the	0 950		

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0 950	Continued From page 10 contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes. R3's Resident Agreement dated August 19, 2025, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R3's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 11 R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's Resident Agreement dated July 1, 2026, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R4's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On September 16, 2026, at 10:04 a.m., director of quality (DQ)-G and director of operations (DO)-H reviewed the licensee's Resident Agreement and stated it did not include a document separate from the contract verbatim notice of Right to Designate a Representative for Certain Purposes. DO-H stated the same Resident Agreement was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 950		

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	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

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0 950	Continued From page 12 (21) days	0 950		
01290 SS=D	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 interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for one of one employee (director of maintenance (DM)-I). 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).	01290		

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01290	Continued From page 13 The findings include: On September 15, 2026, at 12:48 p.m., a review of NETStudy showed that DM-I had been affiliated with a sister facility HFID 30580. On September 15, 2026, at 1:24 p.m., director of operations (DO)-H emailed the surveyor an affiliated background study clearance letter for DM-I dated September 15, 2026, which was completed after the start of survey. On September 16, 2026, at 10:32 a.m., DO-H stated DM-I's background study was affiliated with a sister facility. DO-H stated the licensee affiliated DM-I to the licensee on September 15, 2026, after the start of survey. The licensee's Background Studies policy dated September 1, 2026, indicated all employees, contractors, volunteers, agency staff, owners, managerial officials, and other covered individuals shall successfully complete required state background studies before assuming duties that involve direct contact with residents or unsupervised access to residents or resident property. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted	01460		

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01460	Continued From page 14 living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-J) completed an orientation to assisted living facility licensing requirements	01460		

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01460	Continued From page 15 and regulations before providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: CNS-B CNS-B was hired on June 29, 2026, to provide direct care and services to the facility's residents. CNS-B's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. LPN-J LPN-J was hired on June 23, 2026, to provide direct care and services to the facility's residents. LPN-J's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Handing of resident complaints, reporting of complaints, where to report;	01460		

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01460	Continued From page 16 - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On September 16, 2026, at 10:28 a.m., director of quality (DQ)-G stated the licensee recently switched training companies and thought the courses assigned to CNS-B and LPN-J met the orientation requirements. However, when the surveyor asked for course summaries to verify the course content, DQ-G stated the training company did not have course summaries for each course that would show that CNS-B and LPN-J had completed the required courses listed above. DQ-G stated the licensee was working with the training company to create summaries for each course assigned to staff. The licensee's Orientation and Annual Training policy dated September 1, 2026, indicated all staff must complete an orientation to the assisted living licensing requirements and regulations before providing assisted living services to clients. The training must contain the following topics: a. An overview of this state's Assisted Living requirements and regulations; b. Introduction and review of all the provider's policies and procedures related to the provision of assisted living services; c. Handling of emergencies and use of emergency services; d. Compliance with and reporting of the maltreatment of vulnerable adults; e. Assisted living bill of rights; f. Handing of resident complaints and concerns, reporting of complaints, where to report complaints including the applicable state agencies to report to;	01460		

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01460	Continued From page 17 g. Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disability, Managed Care Ombudsman at the DHS, county managed care advocates or other relevant services; and h. Review of the types of Assisted Living services the employee will be providing an the provider's scope of licensure. i. Infection control policies No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530		

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01530	Continued From page 18 paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four employees (clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-J) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01530		

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01530	Continued From page 19 The findings include: The licensee provided services under an Assisted Living Facility license. CNS-B CNS-B was hired on June 29, 2026, to provide direct care and services to the facility's residents. CNS-B's training transcript included the following courses: -Living with Dementia, completed on June 30, 2026 -Mental Health Awareness, completed on June 30, 2026 -Positive Behavior Support, completed on June 39, 2026 CNS-B's employee record contained evidence the employee completed the courses listed above; however, the training transcript did not include contact hours for any of the courses completed by CNS-B. CNS-B's employee record lacked evidence of completing the required eight hours of dementia care training within 160 hours of the employment start date and lacked evidence of completing the required two hours of mental illness and de-escalation training. LPN-J LPN-J was hired on June 23, 2026, to provide direct care and services to the facility's residents. LPN-J's training transcript included the following courses: -Living with Dementia, completed on June 24, 2026 -Mental Health Awareness, completed on June 26, 2026 -Positive Behavior Support, completed on June	01530		

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01530	Continued From page 20 24, 2026 LPN-J's employee record contained evidence the employee completed the courses listed above, however, the training transcript did not include contact hours for any of the courses completed by LPN-J. LPN-J's employee record lacked evidence of completing the required eight hours of dementia care training within 160 hours of the employment start date and lacked evidence of completing the required two hours of mental illness and de-escalation training. On September 16, 2026, at 10:40 a.m., director of quality (DQ)-G stated the licensee had recently switched training companies and were aware that the training transcripts did not include contact hours for each course. DQ-G stated the licensee was working with the company to include this requirement. DQ-G could not provide any additional information on the number of hours that were completed for each course for CNS-B and LPN-J. The licensee's Orientation and Annual Training policy dated September 1, 2026, indicated direct care employees must have at least eight hours of initial training within 160 hours of employment starting date. Staff must have at least two hours of training on topics related to dementia and one hour of training on topics to mental illness and de-escalation for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01640	Continued From page 21	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of four residents (R3 and 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01640		

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01640	Continued From page 22 of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes. R3's service plan dated August 25, 2025, indicated R3 received services to include compression garments/wraps twice a day, and blood sugar checks twice daily, On September 15, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-E check R3's blood sugar. R3's planned services dated September 2026, included the following: -Blood sugar checks once a day in the morning -Compression Garments/Wraps: assist of one to put lymphedema pneumatic compression boots (device that uses air-filled sleeves to apply sequential pressure, moving fluid out of swollen limbs and mimicking natural lymphatic drainage) on for one hour a day. Resident can take them off on her own. On September 16, 2026, at 10:10 a.m., director of quality (DQ)-G reviewed R3's record and stated the ULP checked R3's blood sugar once a day, not twice a day as indicated in R3's service plan. Clinical nurse supervisor (CNS)-B stated R3 was independent with the application and removal of her compression stockings. CNS-B stated the ULP assisted R3 one time a day with putting on the lymphedema pneumatic compression boots and R3 would remove them herself after one hour. CNS-B stated she would update R3's	01640		

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01640	Continued From page 23 service plan to reflect once a day blood sugar checks and once a day assistance with lymphedema pneumatic compression boots. R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include activity assist, meal reminders, weight checks, blood pressure checks, blood sugar checks, and medication administration. During the entrance conference on September 14, 2026, at approximately 9:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up. CNS-B stated R4 received some medications from the VA which came in bottles. CNS-B stated the nurse would remove the medications from the bottles and package them in bubble packs for the ULP to administer with R4's other medications. R4's service plan did not include medication setup services. On September 16, 2026, at 10:11 a.m., CNS-B stated R4's service plan did not include medication setup services. CNS-B stated she would update R4's service plan to reflect medication setup. The licensee's Service Agreement Contents policy dated September 1, 2026, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the nurse.	01640		

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01640	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of four residents (R1 and R3) who self-administered medications were assessed for self-administration of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1	01710		

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01710	Continued From page 25 R1 was admitted on June 7, 2024, with diagnoses that included diabetes. R1's service plan dated November 1, 2024, indicated R1 received services to include medication administration. On September 14, 2026, at 11:53 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar and administer insulin. The surveyor noted one fluticasone-salmeterol 500/50 inhaler sitting on the tablet in the living room. On September 15, 2026, at 8:03 a.m., the surveyor observed ULP-D review R1's Medication Administration Record (MAR) while preparing to administer medications. ULP-D reviewed the order for fluticasone-salmeterol inhaler and stated R1 kept the inhaler in her room and self-administered it. ULP-D brought R1's medications to her in her apartment. The surveyor noted the fluticasone-salmeterol inhaler sitting on R1's walker. R1 stated she self-administered the inhaler. R1's medication administration record (MAR) dated September 2026, included the following medications: -Fluticasone-salmeterol 500/50 inhaler: inhale one puff by mouth twice daily. Rinse mouth out with water after use, MAR indicates that staff administer this inhaler. -ketoconazole shampoo; Shampoo once daily, leave on for 5-10 minutes, then rinse- self assist -acetaminophen (Tylenol); 500 milligrams (mg); take two tablets by mouth every 9 hours as needed for pain *may keep in room and self-administer-self assist -albuterol inhaler; inhale 2 puffs by mouth every	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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
01710	Continued From page 26 four hours as needed for shortness of breath. *okay to keep in apartment and self administer- self assist -clotrimazole cream 1%; apply topically as needed for fungal rash. Okay to keep in room for self-administration- self assist -diclofenac gel 1%; apply topically two grams four times daily as needed for pain - may self-administer- self assist -hydroxyzine 10 mg; take one tablet by mouth four times daily as needed for itching- self assist -mupirocin ointment 2%; apply topically a pea sized amount to skin lesions on stomach and arms three times daily as needed for one week at a time. *May keep at bedside- self assist -naloxone spray 4 mg; use one spray into nostril as needed for reversal *repeat 2nd device in other nostril if not or minimal response after 2-3 minutes- self assist R1's individualized medication management plan dated August 24, 2026, indicated R1 could self-administer albuterol inhaler, mupirocin ointment, Tylenol and diclofenac gel. All other medications would be administered by the ULP. R1's individualized medication management plan and assessment did not assess R1's ability to self-administer the following medications: -fluticasone-salmeterol 500/50 inhaler: inhale one puff by mouth twice daily. -ketoconazole shampoo; Shampoo once daily, leave on for 5-10 minutes, then rinse -clotrimazole cream 1%; apply topically as needed for fungal rash. -hydroxyzine 10 mg; take one tablet by mouth four times daily as needed for itching -Naloxone spray 4 mg; use one spray into nostril as needed for reversal *repeat 2nd device in other nostril if not or minimal response after 2-3	01710		

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01710	Continued From page 27 minutes- self assist R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes. R3's service plan dated August 25, 2025, indicated R3 received services to include medication administration. R3's MAR dated September 2026, included the following medications: -Bion Tears 0.1-0.3% eye drops; instill one drop into both eyes four times daily -self assist -diclofenac gel 1%; apply to painful areas topically four times a day -self assist -Nivea Cream; apply to lower legs for 14 days and then discontinue. Okay to self-administer- self assist -ketoconazole shampoo; use as directed to shampoo three times weekly. Okay to self-administer- self assist -Nystatin cream; apply topically to abdominal folds twice daily as needed -self assist -Preparation H cream; apply topically to rectal area four times daily as needed -self assist -hydrocortisone cream 1%; apply to affected areas four times daily as needed. Okay to keep in room and self-administer R3's individualized medication management plan dated August 28, 2026, indicated R3 required assistance with medication administration due to complexity of medications. R3's individualized medication management plan and assessment did not assess R3's ability to self-administer the medications listed above. On September 16, 2026, at 10:14 a.m., clinical	01710		

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01710	Continued From page 28 nurse supervisor (CNS)-B stated R1 and R3's individualized medication management plan and assessments did not accurately reflect the medications that R1 and R3 could self-administer. CNS-B stated she would assess R1 and R3 for self-administration of medications and update their records. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy dated October 1, 2026, indicated the RN develops an individualized medication management plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: a. identification of the medication management services to be provided by our facility; b. description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; c. identification of any specific resident instructions regarding medications our facility staff will administer; d. identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis; e. identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; f. procedure for staff to notify the licensed nurse there is a problem with any medication management service; g. any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions.	01710		

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01710	Continued From page 29 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730		

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01730	Continued From page 30 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for four of four residents (R1, R2, R3, and 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 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: During the entrance conference on September 14, 2026, at approximately 9:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents at the facility. CNS-B stated medications were stored in medication carts and	01730		

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01730	Continued From page 31 insulin was stored in central storage refrigerator. R1 R1 was admitted on June 7, 2024, with diagnoses that included diabetes. On September 14, 2026, at 11:53 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar and administer insulin. R1's service plan dated November 1, 2024, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated September 2026, included the following medications: -fluticasone-salmeterol 500/50 inhaler: inhale one puff by mouth twice daily. Rinse mouth out with water after use, MAR indicates that staff administer this inhaler. -ketoconazole shampoo; Shampoo once daily, leave on for 5-10 minutes, then rinse- self assist -acetaminophen (Tylenol); 500 milligrams (mg); take two tablets by mouth every 9 hours as needed for pain *may keep in room and self-administer-self assist -albuterol inhaler; inhale 2 puffs by mouth every four hours as needed for shortness of breath. *okay to keep in apartment and self administer-self assist -clotrimazole cream 1%; apply topically as needed for fungal rash. Okay to keep in room for self-administration- self assist -diclofenac gel 1%; apply topically two grams four times daily as needed for pain - may self-administer- self assist -hydroxyzine 10 mg; take one tablet by mouth four times daily as needed for itching- self assist -mupirocin ointment 2%; apply topically a pea	01730		

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01730	Continued From page 32 sized amount to skin lesions on stomach and arms three times daily as needed for one week at a time. *May keep at bedside- self assist -naloxone spray 4 mg; use one spray into nostril as needed for reversal *repeat 2nd device in other nostril if not or minimal response after 2-3 minutes- self assist -Humalog 100 units/milliliter (ml); inject 4 units subcutaneously every morning with breakfast -Humalog 100 units/ml; inject 12 units subcutaneously with lunch -Humalog 100 units/ml; inject 8 units subcutaneously with supper -Insulin Lisp 100 units/ml; inject per sliding scale -Blood sugar (BS) less than 150 = 0 units -BS 150-179 = 1 unit -BS 189-209 = 2 units -BS 210-239 = 3 units -BS 240-269 = 4 units -BS 270-299 = 5 units -BS 300-329 = 6 units -BS 330-359 = 7 units -BS 360-389 = 8 units -BS 390-419 = 9 units -BS 420-449 = 10 units -BS 450-479 = 11 units -BS 480-509 = 12 units -Mounjaro 2.5/0.5 injection; inject 0.5 ml subcutaneously once a week -Lantus Solostar 100 units/ml; inject 15 units subcutaneously every night at bedtime R1's individualized medication management plan dated August 24, 2026, indicated the following: -Secure storage of controlled medications, specify: controlled medications are stored in narcotic drawer in medication cart under double lock. -Secure storage of all other medications, specify: medications are locked in medication cart.	01730		

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01730	Continued From page 33 -In summary, may self-administer medication safely, specify: yes, albuterol inhaler, mupirocin ointment, Tylenol and diclofenac gel. R1's medication management plan did not include the following: -Refrigeration storage for insulin -Assessment for self-administration that included all medications R1 was known to self-administer -Storage of medications in R1's apartment for the medications R1 self-administered R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. R2's service plan dated January 15, 2026, indicated R2 received services to include medication administration. R2's MAR dated September 2026, included the following insulin orders: -Humalog 100 units/ml; Inject 0-5 units per sliding scale subcutaneously three times daily, max daily dose 30 units -BS 150-199 = 1 unit -BS 200-249 = 2 units -BS 250-299 = 3 units -BS 300-349 = 4 units -BS 350-400 = 5 units -BS greater than 400 notify nursing -Humalog 100 units/ml; inject 3 units subcutaneously three times daily before meals -Lantus Solostar 100 units/ml; inject 18 units subcutaneously every night at bedtime R2's individualized medication management plan dated August 11, 2026, included the following: -Secure storage of controlled medications, specify: controlled medications are stored in	01730		

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01730	Continued From page 34 narcotic drawer in medication cart under double lock. -Secure storage of all other medications, specify: medications are locked in medication cart R2's medication management plan did not include refrigeration storage for insulin. R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes. R3's service plan dated August 25, 2025, indicated R3 received services to include medication administration. R3's MAR dated September 2026, included the following medications: -Bion Tears 0.1-0.3% eye drops; instill one drop into both eyes four times daily -self assist -diclofenac gel 1%; apply to painful areas topically four times a day -self assist -Nivea Cream; apply to lower legs for 14 days and then discontinue. Okay to self-administer- self assist -ketoconazole shampoo; use as directed to shampoo three times weekly. Okay to self-administer- self assist -Nystatin cream; apply topically to abdominal folds twice daily as needed -self assist -Preparation H cream; apply topically to rectal area four times daily as needed -self assist -hydrocortisone cream 1%; apply to affected areas four times daily as needed. Okay to keep in room and self-administer -Trulicity 1.5/0.5; inject 0.5 ml subcutaneously once weekly R3's individualized medication management plan dated August 28, 2026, included the following:	01730		

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01730	Continued From page 35 -Secure storage of controlled medications, specify: controlled medications are stored in narcotic drawer in medication cart under double lock. -Secure storage of all other medications, specify: medications are locked in medication cart. -R1 required assistance with medication administration due to complexity of medications. R3's medication management plan did not include the following: -Refrigeration storage for insulin -Assessment for self-administration that included all medications R3 was known to self-administer -Storage of medications in R3's apartment for the medications R3 self-administered R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include medication administration. R4's MAR dated September 2026, included the following insulin order: -Lantus Solostar 100 units/ml; inject 15 units subcutaneously every morning before meal R4's individualized medication management plan dated August 6, 2026, included the following: - Secure storage of all other medications, specify: medications are locked in medication cart R4's medication management plan did not include refrigeration storage for insulin. On September 16, 2026, at 10:15 a.m., CNS-B stated R1, R2, R3, and R4's medication	01730		

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01730	Continued From page 36 management plans did not include the content as listed above. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy dated October 1, 2026, indicated the RN develops an individualized medication management plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: a. identification of the medication management services to be provided by our facility; b. description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; c. identification of any specific resident instructions regarding medications our facility staff will administer; d. identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis; e. identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; f. procedure for staff to notify the licensed nurse there is a problem with any medication management service; g. any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01750	Continued From page 37	01750		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for three of four residents (R1, R3, and R4) for medication administration delegated to unlicensed personnel (ULP). 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:	01750		

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01750	Continued From page 38 R1 R1 was admitted on June 7, 2024, with diagnoses that included diabetes. R1's service plan dated November 1, 2024, indicated R1 received services to include medication administration. GLUCOSE R1's medication administration record (MAR) dated September 2026, included the following medication: -Glucose chewable 4 milligram (mg) tablets; chew four tablets by mouth once daily PRN for hypoglycemia (low blood sugar) The licensee failed to provide instructions regarding what blood sugar result was considered a low blood sugar to indicate administering PRN glucose chewable tablets. CONSTIPATION -MiraLAX 17 grams; mix 17 grams in 4-8 ounces of water or juice and drink by mouth daily PRN for constipation -Senna 8.6 mg; take one tablet by mouth at bedtime as needed for constipation The licensee failed to provide instructions for the unlicensed personnel (ULP) to understand which PRN medication for constipation should be used in which order. DIARRHEA R1's MAR dated September 2026, included the following PRN medications for diarrhea: -diphenoxylate-atropine2.5 mg; take one tablet by mouth four times daily PRN for diarrhea -loperamide 2 mg; take one capsule by mouth twice daily PRN for diarrhea	01750		

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01750	Continued From page 39 The licensee failed to provide instructions for the ULP to understand which PRN medication for diarrhea should be used in which order. PAIN R1's MAR dated September 2026, included the following PRN medications for pain: -naproxen 500 mg; take one tablet by mouth twice daily PRN for pain -Tramadol 50 mg; take one tablet by mouth once daily PRN for pain The licensee failed to provide instructions for the ULP to understand which PRN medication for pain should be used in which order. On September 16, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated there were no written instructions regarding what was considered a low blood sugar result that indicated the administration of glucose tablets. CNS-B stated there were no written instructions regarding which PRN medication should be given in which order for R1's PRN medications as listed above. R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. On September 15, 2026, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated January 15, 2026, indicated R2 received services to include medication administration. COUGH	01750		

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	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

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01750	Continued From page 40 R2's MAR dated September 2026, included the following PRN medications for cough: -benzonatate 200 mg; take one capsule by mouth three times daily PRN for cough -chest congestion syrup; take 10 milliliters (ml); by mouth every four hours PRN for cough -Mucus Relief 600 mg; take one tablet by mouth twice daily as PRN for cough -Cough drop; give one cough drop by mouth every two hours PRN for cough -Robitussin; give 10 ml every four hours PRN for dry cough The licensee failed to provide instructions for the ULP to understand which PRN medication for cough should be used in which order. SHORTNESS OF BREATH R2's MAR dated September 2026, included the following PRN medications for shortness of breath: -Combivent 20-100 inhaler; inhale one puff by mouth twice daily PRN for shortness of breath -Incruse Ellipta 62.5 micrograms (mcg); inhale one puff orally four times daily and one puff twice daily PRN for shortness of breath -ipratropium/albuterol nebulizer; inhale one vial four times daily PRN for wheezing/shortness of breath The licensee failed to provide instructions for the ULP to understand which PRN medication for shortness of breath should be used in which order. On September 16, 2026, at 10:17 a.m., CNS-B stated there were no written instructions regarding which PRN medications should be given in which order for R3's PRN medications as listed above.	01750		

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01750	Continued From page 41 R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include medication administration. R4's MAR dated September 2026, included the following medication: -TUMS 500 mg; take 1-2 tablets by mouth four times daily PRN for heartburn The licensee failed to provide instructions for the ULP to understand when to give one tablet versus two tablets of TUMS for heartburn. On September 16, 2026, at 10:18 a.m., CNS-B stated there were no written instructions regarding when to give one tablet versus two tablets of TUMS to R4 for heartburn. The licensee's Medication or Physician Orders policy dated October 1, 2026, indicated the licensed nurse will make any changes to the MAR after receiving a prescription for any change in medication or a new medication, including specific written directions for the administration of the new or changed medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup	01770		

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01770	Continued From page 42 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 all the required content for two of two residents (R2 and 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 14, 2026, at approximately 9:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up. R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. R2's service plan dated January 15, 2026, indicated R2 received services to include activity assist, bathing, dialysis port monitoring, meal assistance, meal reminders, safety checks, blood	01770		

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01770	Continued From page 43 sugar checks, medication administration and medication setup. On September 15, 2026, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2 which included Renvela 800 milligrams (mg). R2's medication administration record (MAR) dated September 2026, included the following medication: -Renvela 800 mg; take one tablet by mouth three times daily with meals (chronic kidney disease). R2's progress notes included the following: -May 22, 2026, "Resident brought her bottle of Renvela to this writer. Medication has been bubble packed and put back in the cart". -July 31, 2026, "90 tablets of Renvela 800 mg packed in cold seal bubble packs". R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include activity assist, meal reminders, weight checks, blood pressure checks, blood sugar checks, and medication administration. R4's service plan did not include medication setup. On September 15, 2026, at 7:19 a.m., the surveyor observed ULP-F administer medications to R4 which included gamma-aminobutyric acid	01770		

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01770	Continued From page 44 750 mg. R4's MAR dated September 2026, included the following medications: -gamma-aminobutyric acid 750 mg; give one tablet by mouth twice daily (anxiety) -Melatonin 5 mg; take 2 tablets by mouth every day (sleep) R4's progress notes included the following: -July 21, 2026, "30 capsules of Gamma-aminobutyric acid 750 mg packed in cold seal bubble packs". -July 1, 2026, "93 capsules of Gamma-aminobutyric acid 750 mg and 60 tablets of Melatonin 10 mg packed in cold seal bubble packs". R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On September 16, 2026, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated the nurse documented medication setup in a progress note. CNS-B further stated the progress notes for medication setup did not include the name of the medication, quantity of dose, times to be administered, or route of administration. The licensee's Medication Set Up and Documentation policy dated September 1, 2026, indicated when medications are set up the nurse will print the medication sheet from the electronic health record. The nurse will sign off the medications you are setting up and then scan that medication sheet and upload it to the electronic health record document cloud in the medication set up documentation folder.	01770		

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01770	Continued From page 45 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for three of four residents (R1, R2, and 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 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 on June 7, 2024, with diagnoses that included diabetes.	01820		

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01820	Continued From page 46 On September 15, 2026, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated November 1, 2024, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated September 2026, included the following orders: -Humalog 100 units/milliliter (ml); inject 4 units subcutaneously every morning with breakfast -Humalog 100 units/ml; inject 12 units subcutaneously with lunch -Humalog 100 units/ml; inject 8 units subcutaneously with supper -insulin Lisp 100 units/ml; inject per sliding scale -Blood sugar (BS) less than 150 = 0 units -BS 150-179 = 1 unit -BS 189-209 = 2 units -BS 210-239 = 3 units -BS 240-269 = 4 units -BS 270-299 = 5 units -BS 300-329 = 6 units -BS 330-359 = 7 units -BS 360-389 = 8 units -BS 390-419 = 9 units -BS 420-449 = 10 units -BS 450-479 = 11 units -BS 480-509 = 12 units -Lantus Solostar 100 units/ml; inject 15 units subcutaneously every night at bedtime R1's record lacked signed prescriber orders for the medications listed above. On September 15, 2026, at 9:26 a.m., licensed practical nurse (LPN)-J provided the surveyor with an after visit summary (AVS) dated May 5,	01820		

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01820	Continued From page 47 2026, which included a list of medications and insulin orders; however, the AVS was not signed by R1's provider. On September 16, 2026, at 10:22 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked signed prescriber orders for the insulin orders noted above. R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. On September 15, 2026, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated January 15, 2026, indicated R2 received services to include medication administration. R2's MAR dated September 2026, included the following medication orders: -isosorbide mononitrate 120 mg; give one tablet by mouth daily (chest pain) -fluticasone nasal spray 50 micrograms (mcg); spray one spray into affected nostrils once daily (allergies) -loratadine 10 mg; take one tablet by mouth daily (allergies) -benzonatate 100 mg; take one tablet by mouth three times daily for cough -cetirizine 10 mg; give one tablet by mouth once daily as needed for allergies R2's record lacked sign prescriber orders for the medications listed above. On September 16, 2026, at 10:24 a.m., CNS-B stated R2's record lacked signed prescriber	01820		

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01820	Continued From page 48 orders for the medications noted above. R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. On September 15, 2026, at 7:19 a.m., the surveyor observed ULP-F administer medications to R4. R4's service plan dated August 31, 2026, indicated R4 received services to include medication administration. R4's MAR dated September 2026, included the following medication orders: -sucralfate 1 gram (g); take one tablet by mouth four times a day (acid reflux) -mirtazapine 7.5 mg; take one tablet by mouth daily at bedtime (anxiety) -Gamma-Aminobutyric acid 750 mg; take one tablet by mouth twice daily (anxiety) -Tadalafil 20 mg; give one tablet 30 minutes before sexual activity as needed. Max dose four times in 30 days (erectile dysfunction) R4's record lacked signed prescriber orders for the medications listed above. On September 16, 2026, at 10:25 a.m., CNS-B stated R4's record lacked signed prescriber orders for the medications noted above. The licensee's Medication or Physician Orders policy dated October 1, 2026, indicated the licensed nurse is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, to be managed by our staff are kept in the resident's	01820		

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01820	Continued From page 49 record and that changes in orders are addressed in the resident's medication record and are communicated on a timely basis to all appropriate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

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01940	Continued From page 50 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for four of four residents (R1, R2, R3, and R4) with treatments. 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 on June 7, 2024, with diagnoses that included diabetes. R1's service plan dated November 1, 2024, indicated R1 received services to include blood glucose checks four times a day, and daily pulse checks. On September 14, 2026, at 11:53 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar via Freestyle Libre sensor (device that monitors blood sugar levels continuously).	01940		

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01940	Continued From page 51 R1's medication administration record (MAR) dated September 2026, included the following: -Freestye Kit Sensor; remove old sensor and apply new sensor every 14 days R1's service plan did not include Freestyle Libre sensor management. R1's individualized treatment and therapy plan dated August 24, 2026, lacked the following content: -a statement of the type of services that will be provided; Freestyle Libre sensor management (change every 14 days) R2 R2 was admitted on July 6, 2023, with diagnoses that included diabetes. R2's service plan dated January 15, 2026, indicated R2 received services to include activity assist, bathing, dialysis port monitoring, meal assistance, meal reminders, safety checks, blood sugar checks, medication administration and medication setup. On September 15, 2026, at 7:35 a.m., the surveyor observed ULP-D check R2's blood sugar via Freestyle Libre sensor. R2's medication administration record (MAR) dated September 2026, included the following: -Freestyle Kit Sensor; remove old sensor and apply new sensor every 14 days R2's service plan did not include Freestyle Libre sensor management. R2's individualized treatment and therapy plan	01940		

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01940	Continued From page 52 dated August 11, 2026, lacked the following content: -a statement of the type of services that will be provided; Freestyle Libre sensor management (change every 14 days) R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes. R3's service plan dated August 25, 2025, indicated R3 received services to include activity assist, compression garments/wraps, twice daily blood sugar checks, daily weights and medication administration. R3's planned services dated September 2026, included the following: -Compression Garments/Wraps: assist of one to put lymphedema pneumatic compression boots (device that uses air-filled sleeves to apply sequential pressure, moving fluid out of swollen limbs and mimicking natural lymphatic drainage) on for one hour a day. Resident can take them off on her own. R3's individualized treatment and therapy plan dated August 28, 2026, lacked the following content: -a statement of the type of services that will be provided; lymphedema pneumatic compression boots R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include activity assist, meal reminders, weight checks, blood	01940		

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01940	Continued From page 53 pressure checks, blood sugar checks, and medication administration. On September 15, 2026, at 7:19 a.m., the surveyor observed ULP-F check R4's blood sugar. R3's individualized treatment and therapy plan dated August 6, 2026, lacked the following content: -a statement of the type of services that will be provided; blood sugar checks On September 16, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)-B, and director of quality (DQ)-G reviewed R1, R2, R3, and R4's treatment plans. CNS-B stated R1 and R2's service plan and treatment plans did not include Freestyle Libre sensor management. CNS-B stated R3's treatment plan did not include lymphedema pneumatic compression boots. DQ-G stated R4's treatment plan did not include daily blood sugar checks. The licensee's Treatment or Therapy Services policy dated October 1, 2026, indicated the nurse will create a written, individualized therapy/treatment plan with the resident and/or responsible party. The therapy/treatment plan will include: a. the type of service to be provided b. instructions specific to the resident, relating to the treatment or therapy to be administered c. identification of specific tasks that will be delegated to ULP. d. procedures for notifying the nurse or appropriate healthcare professional if a problem arises with the therapy or treatment service e. any resident-specific requirements related to documentation of therapy or treatment received,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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
01940	Continued From page 54 verification that service was received, and monitoring of therapy or treatment to prevent complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for three of four residents (R1, R3, and R4) receiving treatments. 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).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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
01970	Continued From page 55 The findings include: R1 R1 was admitted on June 7, 2024, with diagnoses that included diabetes. R1's service plan dated November 1, 2024, indicated R1 received services to include blood glucose checks four times a day, and daily pulse checks. R1's service plan did not include Freestyle Libre sensor management. On September 14, 2026, at 11:53 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar via Freestyle Libre sensor (device that monitors blood sugar levels continuously). R1's medication administration record (MAR) dated September 2026, included the following: -Freestyle Kit Sensor; remove old sensor and apply new sensor every 14 days R1's signed prescriber orders dated September 14, 2025, included the following: -Freestyle Kit Sensor; apply new sensor every 14 days -Blood sugar checks four times a day -Blood pressure checks twice a day -Pulse checks once a day R3's record did not include a current order within the past 12 months for Freestyle Libre sensor management, blood sugar checks, blood pressure checks and pulse checks. R3 R3 was admitted on August 15, 2025, with diagnoses that included diabetes.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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
01970	Continued From page 56 R3's service plan dated August 25, 2025, indicated R3 received services to include activity assist, compression garments/wraps, twice daily blood sugar checks, daily weights and medication administration. R3's planned services dated September 2026, included the following: -Compression Garments/Wraps: assist of one to put lymphedema pneumatic compression boots (device that uses air-filled sleeves to apply sequential pressure, moving fluid out of swollen limbs and mimicking natural lymphatic drainage) on for one hour a day. Resident can take them off on her own. -Record weight: Observe and record weight. (Notify nurse if there is a weight gain or loss of six pounds). R3's record lacked signed prescriber orders for lymphedema pneumatic compression boots and daily weights. R4 R4 was admitted on December 14, 2023, with diagnoses that included diabetes. R4's service plan dated August 31, 2026, indicated R4 received services to include activity assist, meal reminders, weight checks, blood pressure checks, blood sugar checks, and medication administration. R4's planned services dated September 2026, included the following: -Record Pulse: Observe and record pulse. Notify nurse if pulse is at or above 100 R4's record lacked signed prescriber orders for	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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
01970	Continued From page 57 daily pulse checks. On September 16, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated R1, R3, and R4's record lacked current prescriber orders for the treatments noted above. The licensee's Treatment or Therapy Services policy dated October 1, 2026, indicated all therapy or treatment ordered by a qualified provider will be implemented in a timely manner and according to policy. Orders must: a. include the resident's name b. identify the treatment or therapy to be provided c. describe the frequency of treatment to be provided d. include any specific instructions for the therapy or treatment services e. be current and renewed at least annually No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

CEDAR LODGE
195 24TH PLACE NW
Owatonna, MN 55060
Steele County
Parcel:

Phone:

License Info

License: HFID 30519

Risk:
License:
Expires on:
CFPM: Donna J. Stromley
CFPM #: 58384; Exp: 04/05/2028

Inspection Info

Report Number: F8044261346
Inspection Type: Full - Single
Date: 9/15/2026 Time: 7:36:52 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-500E Microbial Control: time as a control
3-501.19D *Priority Level: Priority 3 CFP#: 24*
MN Rule 4626.0408D Discontinue using time only as a public health control for raw eggs if serving a highly susceptible population.
COMMENT: Raw shell eggs stored on counter during service.
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

! **New Order: 3-800 Highly Susceptible Population**
3-801.11B *Priority Level: Priority 1 CFP#: 26*
MN Rule 4626.0447B Discontinue using unpasteuerized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages and except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined, when serving a highly susceptible population.
COMMENT: Raw shell eggs used to prepare undercooked eggs to residents.

Note: Eggs were assumed to be pasteurized.
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: Food residues on underside of mixer.
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Donna.

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 F8044261346 from 9/15/2026

Donna Stromley
Culinary Coordinator

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

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

CEDAR LODGE
Owatonna
County/Group: Steele County

Inspection Info

Report Number: F8044261346
Inspection Type: Full
Date: 9/15/2026
Time: 7:36:52 AM

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Hot-Holding
Location: Steam Table at 154.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ground beef**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39.8 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Walk-in Cooler at 38.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Glass Door Cooler at 41.4 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Glass Door Cooler at 37.1 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

CEDAR LODGE
Owatonna
County/Group: Steele County

Inspection Info

Report Number: F8044261346
Inspection Type: Full
Date: 9/15/2026
Time: 7:36:52 AM

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

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30519016	**Date:** 9/14/2026
Facility Name: Cedar Lodge	
Facility Address: 195 24th Place NW, Owatonna, MN 55060	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9, 1031.3, 1010.1.9.7]

   Comments: Egress doors leading out from the C wing of the facility were equipped with magnetic hold close locks which required a code to be entered into a keypad to unlock. Facility staff indicated that these devices were no longer in use to secure the doors and were a remnant of when the unit was used as a memory care facility. During the survey one of the doors equipped with a magnetic hold was locked and could not be readily opened from the egress side. Facility staff had to find a code to unlock the egress door which took considerable time. The requirements for controlled egress hardware were not met, and the locking hardware present during the survey could delay evacuation in an emergency. The magnetic locking system components should be removed or incorporated into an approved controlled egress system with required system modification, permitting and approval.

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

   Comments: No devices capable of detecting carbon monoxide were located in the facility during the survey. Several alarms and detector heads were removed from the hallway ceilings and from within resident rooms, but they did not indicate the ability to detect carbon monoxide. A review of the annual fire alarm system inspection failed to indicate any carbon monoxide detection devices connected to the fire alarm panel system. The licensee indicated they were unaware of any carbon monoxide devices installed in the facility despite gas appliances in the facility. Approved carbon monoxide detection should be installed and maintained in the facility that will alert staff if there is a buildup of carbon monoxide. Adequate carbon monoxide protection was required as several gas appliances were installed in the facility. Proper carbon monoxide protection should be installed and maintained.

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

   Comments: Smoke alarms installed throughout the facility exceeded 10 years in age from date of manufacture. The expired smoke alarms should be replaced and maintained less than 10 years in age and properly functional.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. The staff procedures that were provided to the surveyor by facility staff during the survey did not contain any site-specific information and were not completely filled out, with blank

sections left to fill out details. The facility should have a readily accessible FSEP that should include site-specific staff actions for evacuation. Staff actions should be complete, accurate and specific to the facility to ensure staff are prepared in the event of an emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific resident actions for evacuation during a fire or similar emergency. The resident procedures for evacuation that were provided to the surveyor by facility staff during the survey did not contain any site-specific information and were not completely filled out. The FSEP should include site-specific resident actions for evacuation and should be complete, accurate and specific.