Electronically Delivered

November 21, 2025

Licensee
The Beacon at Mapleton
206 3rd Avenue Northeast
Mapleton, MN 56065

RE: Project Number(s) SL30605016

Dear Licensee:

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

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 . . ."

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30605	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL30605016-0 On Ocotber 20, 2025, through October 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 23, 2025, at 9:54 a.m., director of maintenance (DM)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP titled, Monarch Healthcare Management Emergency Preparedness Evacuations, dated October 25, 2022, failed to include the following: The FSEP included employee procedures for evacuation but failed to provide specific	0 810		

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0 810	Continued From page 5 employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included instructions to evacuate residents vertically and downstairs but the facility only had one floor. The plan included instructions to evacuate residents into an adjacent smoke compartment but this facility did not have separate smoke compartments. The plan included instructions to place the empty room magnet on the door frame of evacuated rooms. Magnets were not observed and DM-H stated that this facility did not have magnets. The FSEP included resident evacuation procedures according to their physical condition but failed to identify which residents required assistance by assessing the individualized unique needs of residents. During an interview on October 23, 2025, at 10:05 a.m., corporate nurse lead (CNL)-C stated resident needs were assessed and kept in "Eldermark", but there were no instructions for staff in the FSEP for how to access the information. CNL-C and DM-H stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms	0 900		

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0 900	Continued From page 6 concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 900		

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0 900	Continued From page 7 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 August 19, 2025, (accompanied by legal representative) with diagnoses that included diabetes and dementia. R1's Medication Administration Record (MAR) dated August 2025, indicated staff administered medications starting on August 19, 2025. R1's record contained a MN Admission Packet including the Assisted Living with Dementia Care Contract dated as signed by R1's legal representative on August 27, 2025, eight days after the licensee provided services to R1. R2 R2 was admitted on September 16, 2025, (accompanied by legal representatives) with diagnoses that included hemiplegia (paralysis on one side of the body) and impaired cognition. R2's MAR dated September 2025, indicated staff administered medications starting on September 16, 2025. R2's record contained a MN Admission Packet including the Assisted Living with Dementia Care Contract dated as signed by R2's legal representative on September 17, 2025, one day after the licensee provided services to R2.	0 900		

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0 900	Continued From page 8 On October 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated R1 and R2's contract was not signed prior to providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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:	01540		

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01540	Continued From page 9 Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D and ULP-G) received the required amount of mental illness and de-escalation training within 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility held an Assisted Living with Dementia Care license effective August 1, 2025, with a current census of 12 residents. During the entrance conference on October 20, 2025, at 10:08 a.m., clinical nurse supervisor (CNS)-B and corporate nurse lead (CNL)-C stated they were aware of the required contents of the employee record. ULP-D ULP-D was hired on April 2, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked documented evidence of completed training in mental illness and de-escalation training by July 1, 2025. ULP-G	01540		

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01540	Continued From page 10 ULP-G was hired on February 2, 2025, to provide direct care and services to the licensee's residents. ULP-G's employee record lacked documented evidence of completed training in mental illness and de-escalation training by July 1, 2025. On October 22, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated the required training had not been completed by ULP-D or ULP-G. CNS-B further stated the mental illness and de-escalation training for staff had not been assigned to any of the licensee's current staff yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
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	01640		

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01640	Continued From page 11 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 interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes and dementia. R1's Assisted Living Agreement Addendum (identified as the service plan) effective August 19, 2025, indicated R1 received services including bathing, AM and PM cares (dressing/grooming), behavior interventions, toileting, blood sugar checks, and medication administration. The service agreement was signed by R1's legal representative on August 19,	01640		

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01640	Continued From page 12 2025; however, the service plan was not signed or authenticated by the licensee until October 20, 2025, when requested by the surveyor. On October 21, 2025, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated when a service plan is created or revised, it is electronically sent to the responsible party for signature. When the document is returned, she is alerted to sign the document but had "missed" authenticating R1's service plan until it was requested by the surveyor. The licensee's Service Plan policy dated revised August 1, 2021, noted the service plan and any revisions must include a signature or other authentication by the assisted living and by the tenant or the tenant's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30605	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 13 (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for one of two residents (R1) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	02170		

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02170	Continued From page 14 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: The facility held an assisted living with dementia care license effective August 1, 2025, with a current census of 12 residents. R1 was admitted on August 19, 2025, with diagnoses that included diabetes and dementia. On October 20, 2025, at 2:00 p.m., the surveyor observed R1 participating in a painting by number activity with other residents in the dining room. R1's Assisted Living Agreement Addendum (identified as the service plan) effective August 19, 2025, indicated R1 received services including bathing, AM and PM cares (dressing/grooming), behavior interventions, toileting, blood sugar checks, and medication administration. R1's record lacked an individualized written activity evaluation prior to October 20, 2025, (when requested by the surveyor) that addressed: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and	02170		

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02170	Continued From page 15 -identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan based on the activity evaluation prior to October 20, 2025, when requested by the surveyor. On October 21, 2025, at 12:18 p.m., corporate nurse lead (CNL)-C stated the activity assessment was dated October 20, 2025, the same date when it was requested by the surveyor. CNL-C indicated the assessment and plan should have been done within the first few days and updated as needed. The licensee's undated, Activities Assessment policy noted the completed activity evaluation is part of the resident's medical record and is updated as needed, upon admission and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320		

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02320	Continued From page 16 by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of six residents (R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD) (chronic lung disease that makes it hard to breathe), and dementia. R1's Assisted Living Agreement Addendum (identified as the service plan) effective August 19, 2025, indicated R1 received services including medication administration. R1's medication administration record (MAR) dated October 2025, included an order for Advair (prevents COPD flare-ups) HFA (hydrofluoroalkane) 230-21 micrograms/actuation (mcg/act) inhale two puffs twice daily. How to use: 1. Shake the inhaler for at least 5 seconds before each spray 2. Inhale the medication by pressing down on the inhaler while breathing in deeply through the mouth	02320		

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02320	Continued From page 17 3. Rinse mouth with water after each use. On October 21, 2025, at 9:39 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. Upon entering R1's room, ULP-D handed the cup with the oral medications to R1, who then consumed the medications with water. ULP-D shook R1's Advair inhaler, then handed the inhaler to R1 and the resident administered independently. ULP-D took the inhaler and then exited the room. ULP-D did not prompt R1 to rinse her mouth with water and spit after administering the inhaler. When interviewed at this time ULP-D stated she did not offer R1 to rinse her mouth following the inhaler administration because "she refuses". On October 21, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated she would expect staff to prompt R1 to rinse mouth after Advair inhaler use per the instructions on the MAR. The manufacturer's Advair HFA Instructions for Use dated revised July 2023, indicated: Step 7. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. The licensee's Medication Administration by Unlicensed Personnel policy dated revised August 2021, noted a procedure for medication administration by ULP: 1. Review medication service schedule/MAR for any instructions for resident for administration. 4. Assemble medications and necessary supplies along with written instructions outlined on the service schedule. No further information was provided.	02320		

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02320	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

The Beacon at Mapleton
206 3RD AVENUE NE
Mapleton, MN 56065
Blue Earth County
Parcel:

Phone:

License Info

License: HFID 30605

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

Inspection Info

Report Number: F1034251158
Inspection Type: Full - Single
Date: 10/21/2025 Time: 11:15:11 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: One person cannot be the CFPM for more than one location. A CFPM must be provided.
Comply By: 12/31/2025 Originally Issued On: 10/21/2025

Food & Beverage General Comment

Inspection conducted in conjunction with HRD.

Discussed cleaning of hood filters in between professional cleanings.

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 Mankato District Office inspection report number F1034251158 from 10/21/2025

Laura Hutchens

McKenna Mathews

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us