Electronically Delivered

August 27, 2025

Licensee
Milestone Senior Living Faribault
2500 14th Street Northeast
Faribault, MN 55021

RE: Project Number(s) SL30613016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 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 addtion to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

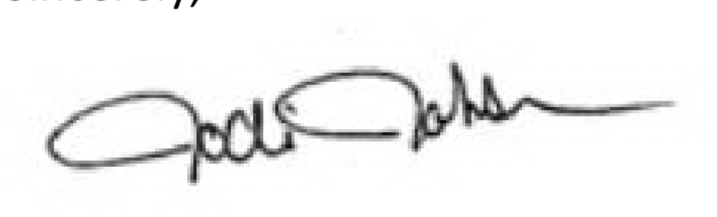
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30613	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING FARIBAULT	2500 14TH ST NE FARIBAULT, MN 55021

(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: SL30613016-0 On July 7, 2025, through July 10, 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 34 residents; 30 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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 July 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to catheter care for one of one resident (R5). 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:	0 510		

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0 510	Continued From page 4 R5's Service Plan dated June 5, 2025, indicated R5 received services which included assistance with medication administration, dressing, grooming/personal hygiene, bathing, catheter care including applying leg bag (small daytime use drainage bag attached to an indwelling catheter for continuous urinary collection) in the morning and bed bag (large nighttime bag use drainage bag attached to an indwelling catheter for continuous urinary collection) at night, laundry, and housekeeping. On July 8, 2025, at 8:34 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R5 with morning cares; this included changing her catheter bed bag to a leg bag. ULP-D had R5 sit down in a chair next to the sink in her bathroom. ULP-D donned gloves and then grabbed R5's leg bag that was hanging from the handicap grab bar next to the toilet. When ULP-D obtained the leg bag from the handicap grab bar, the leg bag tubing connector end drug across the bathroom floor to where R5 was seated. ULP-D disconnected R5's bed bag, spilling urine onto the floor, and attached R5's leg bag to the catheter. ULP-D did not cleanse the leg bag tubing with alcohol prior to connecting it to the indwelling catheter tubing. ULP-D then cleaned up the urine from the floor, doffed her gloves, and washed her hands. The surveyor asked ULP-D when she would use an alcohol wipe, ULP-D stated when attaching the leg bag to the catheter. ULP-D then stated she should have used an alcohol wipe, but she "forgot". On July 9, 2025, at 2:06 p.m., clinical nurse supervisor (CNS)-B stated she would expect the leg bag tubing connector be cleansed with alcohol before connecting it to R5's indwelling catheter.	0 510		

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0 510	Continued From page 5 CNS-B stated that was an infection control issue. The licensee's undated, 2.16 Foley and Suprapubic Catheter Care policy included directions for changing from a straight drainage bag (bed bag) to a leg bag: 8. Clean the leg bag tubing connection and the indwelling catheter hub with an alcohol wipe and connect to the indwelling catheter hub, ensure the clamp on the leg bag is closed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and 911 emergency phone number as required. This had	0 640		

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0 640	Continued From page 6 the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. On July 7, 2025, at 2:42 p.m., the surveyor observed the common areas within the facility and noted there was no posting of the 911 emergency number as required. On July 7, 2025, at 3:20 p.m., licensed assisted living director (LALD)-A stated the 911 emergency number was not posted in common areas or near facility telephones. The licensee's 2.32 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted the community would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility.	0 640		

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0 640	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on July 8, 2025, from 9:57 a.m. through 11:46 a.m. with director of maintenance (DM)-F, the surveyor observed the following: FIRE RATED DOORS Fire rated doors in the first and second floor laundry rooms, basement boiler room, and	0 775		

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0 775	Continued From page 8 memory care wing air handler room and spa room all had evidence that a door closer had been mounted to the door. The closers were removed and disabled so the doors did not automatically self-close as designed. State Fire Code in MN Rules, chapter 7511 requires fire rated doors to be maintained to self-close and latch as designed. CARBON MONOXIDE DETECTION The surveyor observed single station carbon monoxide alarms by the first and second floor gas fireplaces, in the second-floor furnace room and in the basement boiler room. DM-F stated these alarms were not connected to the fire alarm system and would not sound an alarm at a constantly monitored location. State Fire Code in Minnesota Rules, chapter 7511 requires either, rooms that contain a fuel burning appliance be equipped with a carbon monoxide detection system, or carbon monoxide alarms be located within ten feet of every sleeping room. LOCKED EXITS IN MEMORY CARE WING The surveyor observed three exit doors that led into a fenced yard. The surveyor exited the building through one of the doors and observed a locked gate in the fence. When asked about the locked gate DM-F stated the gate lock was not connected to the fire alarm system and there was no switch to deactivate the lock. The doors were shown as emergency exits on the posted evacuation maps. The surveyor observed that the door leading to the assisted living wing was locked and required a code to unlock. DM-F stated that the door would unlock upon activation of the fire alarms	0 775		

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0 775	Continued From page 9 but there was no switch to deactivate the lock. The door was shown as an emergency exit on the posted evacuation maps. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. Locked exits must unlock with activation of the fire alarm system and be capable of being deactivated at an approved location. DRYER DUCTS The surveyor observed lint accumulating behind the dryers in the first and second floor laundry rooms and the memory care laundry room. All three laundry rooms had dryer vents that were disconnected and discharging into the room. Dryer vents must be properly connected and kept clean to not create a fire hazard. DM-Fverified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 10 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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MILESTONE SENIOR LIVING FARIBAULT	2500 14TH ST NE FARIBAULT, MN 55021

(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
01500	Continued From page 11 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began providing assisted living services on June 10, 2024. On July 9, 2025, at 11:15 a.m., the surveyor observed ULP-E administer aspart (fast-acting insulin) to R2. ULP-E's employee record lacked documented evidence of the following required annual training: - Reporting maltreatment of vulnerable adults or minors; - Assisted living bill of rights;	01500		

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01500	Continued From page 12 - Infection control techniques; - Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - Review of the facility's policies and procedures. On July 10, 2025, at 1:30 p.m., licensed assisted living director (LALD)-A indicated ULP-E's training had been archived and he was unable to produce the transcripts of completion. LALD-A stated ULP-E's employee filed lacked the required annual training as noted above. The licensee's 5.04 Annual Required Staff Training policy dated August 1, 2021, identified the following training elements MUST be included every 12 months to all staff who perform direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfection reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders	01500		

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01500	Continued From page 13 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed by two of three employees (unlicensed personnel (ULP)-C, ULP-D) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 14 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: R4 R4's diagnoses included dementia. R4's service plan dated May 15, 2025, indicated R4 received assistance with medication administration. R4's prescriber orders dated March 24, 2025, included: - Boston simplus solution (ocular lubricant) use to moisten ocular prosthesis in LEFT eye three times daily. R4's electronic medication administration record (eMAR) summary dated July 1, 2025, through July 8, 2025, included: - Boston simplus 5 (five) drops three times per day to moisten ocular prosthetic into RIGHT eye. On July 8, 2025, at 7:41 a.m., the surveyor observed ULP-C prepare and administer medications to R4. ULP-C reviewed R4's eMAR and obtained R4's Boston eye drops. ULP-C sanitized her hands, applied gloves, and administered one drop to R4's right eye. ULP-C then removed the gloves, sanitized, and returned to eMAR to document. When interviewed at this time, ULP-C stated she only administered one drop not five drops as identified on eMAR. In addition, ULP-C stated the Boston simplus label	01760		

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01760	Continued From page 15 directed to administer to left eye, and indicated the label was incorrect as his artificial eye was on his right. ULP-C stated all medication should be administered as ordered or direct questions to the nurse. R5 R5's diagnoses included unspecified dementia. R5's service plan dated June 5, 2025, indicated R5 received assistance with medication administration. R5's most recent prescriber orders dated April 17, 2024, (greater than one year ago) included an order for polyethylene glycol 3350 (laxative). Mix 17 grams in 4-8 ounces of water or other beverage, then drink by mouth daily. R5's eMAR summary dated July 1, 2025, through July 8, 2025, included the medication as ordered above. On July 8, 2025, at 8:45 a.m., the surveyor observed ULP-D prepare and administer medications to R5. ULP-D reviewed R5's eMAR and obtained R5's polyethylene glycol 3350 from the locked medication cupboard in R5's apartment. ULP-D poured the polyethylene glycol 3350 powder into the cap of the medication bottle halfway from line identifying 17 grams. ULP-D then poured the powder into a glass of water, stirred, and administered the drink to R5. When interviewed at this time, ULP-D stated she thought 17 grams was in the middle of the cap not the full cap as identified by the 17-gram line on the cap of the medication. R2 R2's diagnoses included diabetes.	01760		

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01760	Continued From page 16 R2's service plan dated July 3, 2025, indicated R2 received assistance with medication administration. R2's prescriber orders dated April 28, 2025, and May 8, 2025, included: -aspart (fast-acting insulin) 14 units with meals. Hold if blood glucose less than 100, notify nurse if blood glucose less than 70 or greater than 450. -Semglee (a long-acting insulin) inject 80 units subcutaneously at bedtime. R2's eMAR summary dated July 1, 2025, through July 8, 2025, included the medications as noted above. On July 8, 2025, at 11:49 a.m., the surveyor observed ULP-D check R2's blood sugar using a Libre reader (sensor that provides glucose readings without fingersticks) and obtained a result of 218 milligrams/deciliter (mg/dL). ULP-D reviewed R2's eMAR indicating she would be administering insulin based on that result and obtained R2's Semglee insulin. ULP-D used an alcohol wipe to cleanse the hub of the insulin pen and applied a new needle. ULP-D then turned the dial to two units and held the pen horizontally to prime the needle. ULP-D then turned the dial to 14 units and administered the insulin in R2's right lower abdomen over about three seconds. When interviewed at this time, ULP-D stated you could prime the pen holding it either horizontal or vertically. ULP-D further stated she had not counted to 10 while administering the insulin but knew she should have. On July 9, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated she would need to have the order clarified for R4's Boston simplus	01760		

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01760	Continued From page 17 solution as the order identified administration to the LEFT eye but R4's prosthetic eye was his RIGHT. CNS-B would expect staff to bring this to her attention if the eMAR and labels did not match and would expect staff to follow the eMAR or notify her of problems. CNS-B further stated staff were taught and instructed to use the 17-gram line inside of the medication lid for accurate measurement of polyethylene glycol. In addition, CNS-B stated she instructed staff to hold the insulin pen vertically when priming and insulin should be administered over five seconds or longer. CNS-B further stated ULP-D had administered the wrong insulin (Semglee instead of the aspart) indicating ULP-D had made a medication error. The Semglee manufacturer instructions for use dated revised November 2023, included Step 5: Injecting your Semglee dose: - Choose a place to inject; - Push the needle into your skin; - Place your thumb on the injection button. Then press all the way in and hold; - Keep the injection button held in and when you see"0" in the dose window, slowly count to 10. This will make sure you get your full dose. - After holding and slowly counting to 10, release the injection button. Then removed the needle from your skin. The licensee's 7.05 Medication Management - Administration & Setup policy dated August 1, 2021, noted ULP trained to provide medication administration would document any medication administration provided accurately in each resident record. ULP would also document any problems with medication administration and document or communicate to the nurse any reason why medication administration was not	01760		

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01760	Continued From page 18 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when the medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the prescription label for three of four residents (R4, R5, R2), and failed to ensure time sensitive medications had an opened date for one of one resident (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 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	01890		

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01890	Continued From page 19 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4's diagnoses included dementia. R4's service plan dated May 15, 2025, indicated R4 received assistance with medication administration. R4's prescriber orders dated March 24, 2025, included: - deep sea saline 0.65% nasal spray instill one spray in each nostril three times daily. R4's electronic medication administration record (eMAR) summary dated July 1, 2025, through July 8, 2025, included the medication as ordered above. On July 8, 2025, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer deep sea saline one spray to each nostril to R4. The nasal spray bottle was labeled with R4's name but lacked instructions. When interviewed at this time, ULP-C stated there should be a box or bag that the nasal spray is kept in that would have the label. ULP-C was unable to find the box/bag for R4's nasal spray. R5 R5's diagnoses included unspecified dementia. R5's service plan dated June 5, 2025, indicated R5 received assistance with medication administration. R5's most recent prescriber orders dated April 17,	01890		

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01890	Continued From page 20 2024, (greater than one year ago) included: -Refresh Relieva (ocular lubricant) 0.5-0.9% one drop in both eye three times daily. R5's eMAR summary dated July 1, 2025, through July 8, 2025, included the medication as ordered above. On July 8, 2025, at 8:45 a.m., the surveyor observed ULP-D administer R5's morning medications including Refresh Relieva eye drops in R5's apartment. The surveyor noted there was no label on R5's Refresh Relieva eye drops. ULP-D stated the eye drops should be kept in a bag with the label and indicated someone probably threw the bag away. R2 R2's diagnoses included diabetes. R2's service plan dated July 3, 2025, indicated R2 received assistance with medication administration. R2's prescriber orders dated April 28, 2025, and May 8, 2025, included: -aspart (fast-acting insulin) 14 units with meals. Hold if blood glucose less than 100, notify nurse if blood glucose less than 70 or greater than 450. -Semglee (a long-acting insulin) inject 80 units subcutaneously at bedtime. R2's eMAR summary dated July 1, 2025, through July 8, 2025, included the medications as noted above. On July 9, 2025, at 11:15 a.m., the surveyor observed ULP-E administer R2's aspart insulin. No open date or label was present on R2's aspart insulin pen and no date open was present on	01890		

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01890	Continued From page 21 R2's Semglee pen. ULP-E stated the aspart insulin pen was lacking a label and both pens were lacking dates when opened. ULP-E stated insulin pens should have labels and be dated when opened. On July 9, 2025, at 1:55 p.m., clinical nurse supervisor (CNS)-B stated all medications should have a label to include directions for use that match the order and eMAR. CNS-B further stated insulin should be dated when opened since it is a time sensitive medication. The NovoLog (insulin aspart) FlexPen manufacturer instructions for use dated revised February 2023, indicated the NovoLog FlexPen should be thrown away after 28 days, even if it still has insulin left in it. The Semglee manufacturer instructions for use dated revised November 2023, indicated to only use your pen for up to 28 days after its first use. Throw away the Semglee pen you are using after 28 days, even if it still has insulin left in it. The licensee's 7.30 Nose Drops & Nasal Spray policy dated August 1, 2021, noted: e. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -Resident name -Name of the medication -The strength and dosage of the medication -The route -The time that the medication is to be given -Any special instructions f. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions.	01890		

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01890	Continued From page 22 The licensee's 7.25 Eye Drops and Eye Ointment policy dated August 1, 2021, noted: E. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -Resident name -Name of the medication -The strength and dosage of the medication -The route -The time that the medication is to be given -Any special instructions F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The licensee's 7.08 Medication Storage policy dated August 1, 2021, noted medications would be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 23 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On July 8, 2025, at 11:49 a.m., the surveyor requested documents from licensed assisted living director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility. During an interview on July 8, 2025, at 12:11 p.m., LALD-A verified that the licensee was not able to provide documentation of a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. No further information was provided.	02040		

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02040	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not 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 finding include: On July 7, 2025, at 2:42 p.m., the surveyor observed the front entrance and entryway of the facility. No posting for electronic monitoring was observed.	03090		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING FARIBAULT	2500 14TH ST NE FARIBAULT, MN 55021

(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
03090	Continued From page 25 On July 7, 2025, at 3:20 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a posting regarding electronic monitoring. LALD-A indicated they used to have a television screen at front entrance that included required postings and had stopped using the streaming service about 2 months prior. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Milestone Senior Living

2500 14TH STREET NE

Faribault, MN 55021
Rice County
Parcel:

Phone:

License Info

License: HFID 30613

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

Inspection Info

Report Number: F1034251052
Inspection Type: Full - Single
Date: 7/8/2025 Time: 10:45:05 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
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: Natalie De Leon took a food safety course but did not register with the State as a Certified Food Protection Manager (CFPM) after passing the exam. A CFPM is required. More info here: https://www.health.state.mn.us/communities/environment/food/cfpm/cfmfs.html
Comply By: 8/31/2025 Originally Issued On: 7/8/2025

New Order: 3-200B Food Characteristics:Receiving: temperature, condition
3-202.15 *Priority Level: Priority 2 CFP#: 13*
MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.
COMMENT: Multiple dented cans found in dry storage. PIC stated they would discard.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: Temperature test strips or irreversible thermometer is needed for dishwasher. Should be using at least every other day. Temperature should reach at least 160 degrees F.
Comply By: 7/22/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Need sink and surface sanitizer test strips. The test strips that were on hand (QAC/Quat) are not the right kind for the sanitizer that is currently being used.
Comply By: 7/22/2025 Originally Issued On: 7/8/2025

! **New Order: 5-400 Sewage**
5-402.11A *Priority Level: Priority 1 CFP#: 52*
MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.
COMMENT: There is currently not a visible air gap for both ice machine drain hoses.
This order was originally written during the HRD survey in December 2022.
Comply By: 8/8/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

Inspection conducted in conjunction with HRD.

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 F1034251052 from 7/8/2025

Spencer Holtorf

McKenna Mathews

McKenna Mathews, RS
Public Health Sanitarian 2
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