Electronically Delivered

August 12, 2025

Licensee
Circle Drive Manor Assisted Living LLC
56733 State Highway 56 South
Berne, MN 55985

RE: Project Number(s) SL30326016

Dear Licensee:

On July 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 8, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

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June 30, 2025

Licensee
Circle Drive Manor Assisted Living LLC
56733 State Highway 56 South
Berne, MN 55985

RE: Project Number(s) SL30326016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30326	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HIGHWAY 56 SOUTH BERNE, MN 55985

(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 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: SL30326016-0 On May 5, 2025, through May 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on May 5, 2025, at a level 3/Widespread (I). The licensee took action on May 5, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of two residents (R6, R7). 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:	0 430		

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0 430	Continued From page 2 R6 and R7's records lacked evidence the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract R6 R6's diagnoses included type 2 diabetes, congestive heart failure and hypertension. R6's Service Plan dated March 13, 2024, indicated R6 received services including medication management, blood sugar monitoring, and assistance with bathing. R7 R7's diagnoses included cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management, blood sugar monitoring, suprapubic catheter (a urinary catheter placed through the abdominal wall into the bladder) management, compression wraps, assistance with dressing, grooming, bathing, transfers and repositioning in bed and in wheelchair. On May 6, 2025, at 12:00 p.m., licensed assisted living director (LALD)-A stated she was not aware each resident was to receive a copy of the	0 430		

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0 430	Continued From page 3 UDALSA at or before time of admission; but had the UDALSA posted on the bulletin board with other postings and thought that was sufficient. LALD-A stated she would follow up with all residents to ensure they receive a copy. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated August 1, 2021, indicated [licensee name] will provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an Assisted Living contract. Additionally, the policy indicated the facility will obtain written acknowledgement from the resident or resident representative that [licensee name] provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 4 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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 licensee held an assisted living license and was licensed for a capacity of 10 residents with a current census of 10 residents.	0 470		

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0 470	Continued From page 5 On May 5, 2025, at 12:00 p.m., the licensee's staffing plan was requested. On May 6, 2025, at 8:05 a.m., the surveyor received and reviewed the licensee's staffing plans dated August 14, 2023, and August 2, 2024, and were created by licensed assisted living director (LALD)-A. The plans lacked an indication they were developed by the registered nurse (RN) and lacked clear staffing numbers for each shift. On May 6, 2025, at 8:10 a.m., LALD-A stated she and the RN updated the plan when there were changes with the residents, such as a change in condition or when a resident is dying or on hospice services. LALD-A stated she needed to document these changes with the RN more consistently. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. The licensee's Staffing policy dated August 1, 2021, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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 6 (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 7 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 May 6, 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 8 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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).	0 580		

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0 580	Continued From page 9 The findings include: On May 5, 2025, at 11:00 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated she didn't have a formal plan written; however, LALD-A had meetings with owner/unlicensed personnel (O/ULP)-B to review various things, and was not consistent with having meeting notes. The licensee's Quality Management Project policy dated August 1, 2021, indicated [licensee name] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	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	0 630		

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0 630	Continued From page 10 by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R6, R7). 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: R6 R6 was admitted on March 14, 2024, to receive services under the facility's assisted living license with diagnoses including type 2 diabetes, congestive heart failure and hypertension. R6's Service Plan dated March 13, 2024, indicated R6 received services including medication management, blood sugar monitoring, and assistance with bathing. On May 6, 2025, at 5:54 a.m., the surveyor observed unlicensed personnel (ULP)-D administer morning oral medications and complete R6's insulin injection. R6's IAPP dated March 27, 2025, and lacked an indication of R6's susceptibility to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults.	0 630		

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(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
0 630	Continued From page 11 R7 R7 was admitted on March 28, 2000, to receive services under the facility's assisted living license with diagnoses including cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management, blood sugar monitoring, suprapubic catheter (a urinary catheter placed through the abdominal wall into the bladder) management, compression wraps, assistance with dressing, grooming, bathing, transfers and repositioning in bed and in wheelchair. On May 6, 2025, at 6:35 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B provide morning cares to R7, including changing R7's urinary bag to a leg bag, dressing, and assisting with dressing and transferring to a wheelchair. R7's IAPP dated April 26, 2025, included a statement in number 25. indicating "use of telephone, vulnerable?" with the response, "yes", and number 26. indicating "management of personal finances, vulnerable?" with the response, "yes". R7's IAPP indicated "staff assist with use of the phone" for number 25 intervention, and "family manage finances" as the intervention for number 26. R7's IAPP lacked an indication of R7's susceptibility to abuse/neglect by others and failed to implement interventions to minimize his abuse by others including other vulnerable adults. The licensee failed to recognize that R7 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the	0 630		

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0 630	Continued From page 12 licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. On May 8, 2025, at 10:30 a.m., licensed assisted living director (LALD)-A stated all residents were vulnerable adults and susceptible to abuse, neglect and other forms of abuse. She further stated all resident's IAPPs would need to be reviewed to accurately depict their susceptibility to abuse from others. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. Furthermore, the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2. For purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly	0 650		

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0 650	Continued From page 13 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-D). 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).	0 650		

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0 650	Continued From page 14 The findings include: ULP-D began employment with the licensee on August 23, 2022. On May 6, 2025, at 5:50 a.m., the surveyor observed ULP-D administer medications to R7. ULP-D's record lacked evidence of documentation of annual performance reviews that identified areas of improvement needed and training needs. On May 8, 2025, at 12:15 p.m., licensed assisted living director (LALD)-A stated ULP-D had not had an annual performance review and added, "we try, but we are missing some employees; we have informal sit and talk sessions, but I don't write anything down". The licensee's Personnel Records policy dated August 2, 2021, noted the personnel record for each person would include at minimum, performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 15 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (unlicensed personnel (ULP)-D, 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 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: TB PREVENTION PROGRAM During the entrance conference on May 5, 2025,	0 660		

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0 660	Continued From page 16 at 11:00 a.m. with licensed assisted living director (LALD)-A and owner/unlicensed personnel (O/ULP)-B, a request was made to review the facility TB risk assessment. LALD-A stated the facility TB risk assessment had likely not been done for quite some time. On May 6, 2025, at 11:20 a.m., the surveyor received the facility TB risk assessment dated November 11, 2019. LALD-A stated that was the most recent assessment she could find and was likely accurate. LALD-A stated she thought the TB risk assessment needed to be done "every couple of years". LALD-A stated the assessment provided was more than a "couple" years. The licensee failed to complete a facility TB risk assessment annually as required. ULP-D ULP-D's employee record indicated a hire date of August 23, 2022. On May 6, 2025, at 5:30 a.m., the surveyor observed ULP-D administer medications to R7. ULP-D's employee record included a TST with a negative result on October 28, 2022; however, the record lacked a symptom screening and second step TST or other evidence of TB screening such as a blood test. On May 8, 2025, at 9:15 a.m., O/ULP-B stated he was not aware ULP-D had not completed the required second step TST. He further stated he could not find a symptom screening for ULP-D. ULP-E ULP-E's employee record indicated a hire date of January 20, 2025.	0 660		

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0 660	Continued From page 17 On May 7, 2025, at 12:00 p.m., LALD-A stated ULP-E was an active staff and provided direct care services to the residents in the facility. ULP-E's employee record included a TB symptom screening dated February 22, 2024, and TST testing completed on February 22, 2024, and March 24, 2024, (both with negative results for TB). On May 8, 2025, at 9:15 a.m., O/ULP-B stated after reviewing the facility TB plan, he just realized ULP-E's TB testing and symptom screening was greater than 90 days prior to hire. He further stated ULP-E would need to redo her symptom screening and testing to be in compliance with requirements. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated [licensee name] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. New	0 660		

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0 660	Continued From page 18 staff will be screened for active signs of TB using the Baseline TB Screening Tool for health care workers (HCWs). New staff will have a blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 19 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements and failed to post the plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 5, 2025, at 11:00 a.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was discussed. Licensed assisted living director (LALD)-A and owner/unlicensed personnel (O/ULP)-B stated they had done some work since the last survey and had recently attended a conference and received further training with EP requirements; however, had not yet had the opportunity to review or update their EP plan. LALD-A stated she knew there would be missing required elements. On May 8, 2025, at 12:15 p.m., the surveyor met with LALD-A and O/ULP-B to review the licensee's EP plan. The full plan was found in a	0 680		

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0 680	Continued From page 20 binder in the locked office. An abbreviated plan was posted in a main hallway of the facility. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - the licensee's plan lacked evidence it was reviewed/updated since its creation (following the previous survey in 2022); - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident	0 680		

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0 680	Continued From page 21 command center, or designee; and - the licensee failed to review the missing resident procedure quarterly as required. On May 8, 2025, at 12:45 p.m., LALD-A and O/ULP-B indicated the above listed requirements "still needed work" and had planned on reviewing the required content as they had just been to a conference to better understand the EP plan. The licensee's Emergency Preparedness Plan-Appendix Z Compliance, dated August 1, 2021, indicated [licensee's name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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,	0 810		

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0 810	Continued From page 22 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 23 The findings include: On May 6, 2025, from 2:45 p.m. to 4:30 p.m., license assisted living director (LALD)-A 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 "Fire Policy", undated, failed to include the following: RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/Internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On May 6, 2025, at 3:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was	0 810		

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0 810	Continued From page 24 offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No other training documentation was provided. On May 6, 2025, at 3:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills Report", undated, indicated evacuation drills were conducted on June 13, 2024, and August 13, 2024. No other documentation was provided. On May 6, 2025, at 3:30 p.m., LALD-A stated they have a lot of part-time staff, and it was very difficult to schedule drills. LALD-A understands the statue requirements and will implement a new drill schedule immediately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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(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
01440	Continued From page 25 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (ULP-D, ULP-E) performing delegated tasks was provided by the registered nurse (RN) within 30 calendar days after the date on which the individuals began working for the licensee. 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	01440		

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	30326	A. BUILDING: _____ B. WING _____	05/08/2025

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01440	Continued From page 26 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 5, 2025, at 11:00 a.m. during entrance conference, licensed assisted living director (LALD)-A stated the licensee was not consistent with completing the 30-day RN supervisory observations. ULP-D ULP-D's employee record indicated a hire date of August 23, 2022. On May 6, 2025, at 5:30 a.m., the surveyor observed ULP-D administer medications to R7. ULP-E ULP-E's employee record indicated a hire date of January 20, 2025. On May 7, 2025, at 12:00 p.m., LALD-A stated ULP-E was an active staff and provided direct care services to the residents in the facility. ULP-D and ULP-E's employee files lacked evidence the licensee's registered nurse (RN) completed a 30-day supervisory observation. On May 8, 2025, at 12:20 p.m., LALD-A stated ULP-D and ULP-E likely did not have the required RN supervisory observations completed as there was no record of them in their employee files. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days	01440		

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01440	Continued From page 27 after the date on which the individual begins working for [licensee name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	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; (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;	01500		

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01500	Continued From page 28 (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, 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 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)-D). 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	01500		

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01500	Continued From page 29 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: ULP-D began providing direct care services on August 23, 2022, under the licensee's assisted living license. ULP-D's employee record included the required eight hours of annual training; however, the record lacked evidence the employee had successfully completed annual training to include the following required topics: -reporting maltreatment of vulnerable adults or minors; and -principles of person-centered planning/service delivery On May 8, 2025, at 12:10 p.m., owner/unlicensed personnel (O/ULP)-B indicated he didn't know the exact requirements for annual training when assigning them. O/ULP-B stated although most staff were hired within the last year, he would need to review training as all were currently being assigned this year's training courses. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated the following training elements MUST be included every 12 months to all staff who performs direct care services: - training on reporting of maltreatment of vulnerable adults under section 626.557; and - principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 30 support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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01530	Continued From page 31 Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received the required amount of dementia care 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under the Assisted Living license. ULP-E's employee record indicated a hire date of January 20, 2025. On May 7, 2025, at 12:00 p.m., LALD-A stated ULP-E was an active staff and provided direct care services to the residents in the facility. ULP-E's employee record included two hours of dementia related training dated April 19, 2025; however, ULP-E's record did not include the required eight hours of training within 160 working hours of the employment start date as required. Furthermore, ULP-E's record lacked the required dementia related training topics to include: -an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; and - person centered planning and service delivery	01530		

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01530	Continued From page 32 On May 8, 2025, at 12:15 p.m., LALD-A stated she thought the requirement was four hours of dementia training. Owner/unlicensed personnel (O/ULP)-B stated ULP-E has likely worked greater than 160 hours. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date, and would include the required topics of: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	01700		

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01700	Continued From page 33 medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R6) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 5, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to all the	01700		

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01700	Continued From page 34 residents receiving assisted living services. R6 was admitted under the facility's Assisted Living Facility (ALF) license on March 14, 2024, with diagnoses including type 2 diabetes, congestive heart failure and hypertension. R6's Service Plan dated March 13, 2024, indicated he received medication administration and medication set up. On May 5, 2025, at 5:54 a.m., the surveyor observed unlicensed personnel (ULP)-D set up and administer one oral and one injectable medication for R6. R6's medication administration record (MAR) dated April 2025, included one oral medication for diabetes, one injection for diabetes, one medication for thyroid, one for gout, one for the heart, two for cholesterol, one for heart failure, one for constipation, one for heart rate control, one for mild pain, one for angina, two skin barriers, one topical (on the skin) for rash and three supplements. R6's assessments dated March 18, 2024 (admission assessment), and April 1, 2024, (14-day assessment) lacked evidence the assessment was conducted face-to-face with the resident. The assessments lacked an identification and review of all medications the resident is known to be taking, to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Furthermore, the assessment failed to identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to	01700		

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01700	Continued From page 35 the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On May 8, 2025, at 10:35 a.m., LALD-A stated she and the RN were not aware of the medication assessment requirement nor the required content, and would need to review the electronic medical record used to have it added to the assessment tool used. LALD-A stated the medication assessment tool was not used for any of the residents. The licensee's Medication Management-Assessment, Reassessment, and Monitoring policy dated August 1, 2021, indicated [licensee name] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility 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.	01710		

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01710	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment of medication management services at a minimum annually included all required content for one of one resident (R7). 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). R7 was admitted on March 28, 2000, to receive services under the facility's assisted living license with diagnoses including cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management. On May 6, 2025, at 8:15 a.m. during medication cart review, the surveyor observed a med-minder box containing pills set up for administration. Owner/unlicensed personnel (O/ULP)-B stated R7's morning medications had already been administered by staff. R7's medication administration record (MAR) dated April 2025, included scheduled medications including one inhaler, one eye drop, one eye ointment, two blood pressure medications, one supplement, one medication for bladder spasms, one for acid reflux, one for depression, one for	01710		

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01710	Continued From page 37 cholesterol, one for diabetes, one for edema, one for constipation, and one nasal medication. R7's same orders included the following as needed (PRN) medications: two skin barriers, one antifungal topical cream, two for mild pain, one nebulizer for breathing, one topical pain medication, two topical antibiotic ointments, one oral medication for abdominal gas, five for constipation, one for lactose intolerance, one for diarrhea, one for migraine headaches, one for nausea, one for cough, and one for heartburn. R7 's assessments dated October 28, 2024, January 26, 2025, and April 26, 2025, lacked evidence the required annual medication assessment was conducted to include: - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - the dosage; - the frequency of use; - the route administered or taken; - any difficulties the resident faces in taking the medication; - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and - provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; On May 7, 2025, at 12:30 p.m., licensed assisted	01710		

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01710	Continued From page 38 living director (LALD)-A stated the licensee's registered nurse (RN) was not aware of the medication assessment requirement and the required content. She further stated she was not able to find the assessment tool and would reach out to the electronic medical record (EMR) company for further direction in how to "pull this assessment and the required content" into assessments for all residents. The licensee's Medication Management-Assessment, Monitoring, and Reassessment policy dated August 1, 2021, indicated: 1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [licensee name] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided.	01710		

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01710	Continued From page 39 TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility 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, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730		

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	30326	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HIGHWAY 56 SOUTH BERNE, MN 55985

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01730	Continued From page 40 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 interview and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of two residents (R7). 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: R7 was admitted on March 28, 2000, to receive services under the facility's assisted living license with diagnoses including cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management. On May 6, 2025, at 8:15 a.m. during medication cart review, the surveyor observed a med-minder box containing pills set up for administration.	01730		

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01730	Continued From page 41 Owner/unlicensed personnel (O/ULP)-B stated R7's morning medications had already been administered by staff. R7's MAR dated April 2025, included scheduled medications including one inhaler, one eye drop, one eye ointment, two blood pressure medications, one supplement, one medication for bladder spasms, one for acid reflux, one for depression, one for cholesterol, one for diabetes, one for edema, one for constipation, and one nasal medication. R7's same orders included the following as needed (PRN) medications: two skin barriers, one antifungal topical cream, two for mild pain, one nebulizer for breathing, one topical pain medication, two topical antibiotic ointments, one oral medication for abdominal gas, five for constipation, one for lactose intolerance, one for diarrhea, one for migraine headaches, one for nausea, one for cough, and one for heartburn. R7's medication plan dated January 1, 2025, indicated the licensee managed R7's medications; however, the plan lacked any indication of which tasks were delegated to ULP (was blank/nothing selected). On May 8, 2025, at 10:40 a.m., licensed assisted living director (LALD)-A stated R7's medication plan had missing routes of administration (delegated tasks) and needed to be corrected to include the accurate information. The licensee's Individualized Medication Management Plan and Record policy dated August 1, 2021, indicated the licensee would develop a medication plan to include identification of medication management tasks that may be delegated to unlicensed personnel.	01730		

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01730	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-D, owner/ULP-B) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for two of two residents with insulin (R5, R6). Furthermore, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for two of four residents (R4, R7) for medication administration delegated to unlicensed personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01750		

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01750	Continued From page 43 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: INSULIN ADMINISTRATION R5 R5 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on December 13, 2023, with diagnoses including type 2 diabetes. R5's Service Plan dated January 3, 2025, included the service of medication administration. R5's signed medication orders dated August 23, 2024, included Lispro 100 units/milliliter (u/ml), inject 7 units three times daily for diabetes. On May 6, 2025, at 5:40 a.m., the surveyor observed ULP-D set up and administer nine oral medications, one inhaler, and one injectable medication. ULP-D was observed to pull out R5's Lispro insulin pen from the locked medication cart and applied a new needle to the pen. ULP-D failed to wipe the insulin pen's rubber tip prior to placing a new needle to the pen, and immediately dialed the insulin pen to the designated 7 units of lispro insulin and injected the insulin. ULP-D did not prime the insulin pen with two units of insulin prior to dialing the pen to the designated dose to be given. On May 6, 2025, at 11:25 a.m., the surveyor observed O/ULP-B obtain R5's Lispro insulin pen from the locked medication cart, placed a new cap on the pen, primed the pen with 2 units of	01750		

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01750	Continued From page 44 insulin, and dialed the pen to the designated dose of 7 units of insulin. O-ULP-B did not wipe the rubber tip of the insulin pen with an alcohol prep prior to placing a new needle. R6 R6 was admitted to the facility under the facility's ALF license on March 14, 2024, with diagnoses including type 2 diabetes, congestive heart failure and hypertension. R6's Service Plan dated March 13, 2024, indicated he received the service of medication administration. R6's signed medication orders dated April 29, 2025, included Basaglar 100 u/ml, inject 10 units daily for diabetes. On May 5, 2025, at 5:54 a.m., the surveyor observed ULP-D set up and administer one oral and one injectable medication. ULP-D obtained R6's Basaglar insulin pen from the locked medication cart and apply a new needle to the pen. ULP-D did not wipe the insulin pen's rubber tip prior to placing a new needle, and then immediately dialed the insulin pen to the designated 10 units (per dose indicated on the medication administration record (MAR) and injected the insulin. On May 6, 2025, at 12:00 p.m., licensed assisted living director (LALD)-A stated staff had been trained and was expected to both prime the insulin pens with the designated two units of insulin and wipe the rubber tip with an alcohol wipe prior to applying a new needle. PRN MEDICATIONS R4	01750		

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01750	Continued From page 45 R4 was admitted on September 8, 2012, with diagnoses including encephalitis (brain infection), encephalomyelitis (swelling of the brain and spinal cord), anxiety, adjustment disorder with depression and chronic pain. R4's Service Plan dated January 3, 2025, indicated R4 received services including medication management. On May 6, 2025, at 5:30 a.m., the surveyor observed ULP-D administer 11 oral medications, and one eye drop medication. R4's signed prescriber orders dated April 8, 2025, included one medication for cholesterol, one for depression, four for constipation, two for pain, one for sleep, and four supplements. R4's same orders included the following PRN medications: two for pain, one barrier skin cream, five medications for constipation, and two for skin rashes. R4's medication administration record (MAR) dated April 2025, included the following PRN medications: -acetaminophen 500 milligrams (mg), give two tablets every six hours as needed for pain -ibuprofen 200 mg tablets, give orally PRN -Naproxen 550 mg, give orally PRN -bisacodyl suppository 10 mg, give one suppository daily PRN for constipation -bisacodyl 5 mg tablet, give two tablets orally everyday PRN for constipation -Colace 100 mg, give one capsule orally PRN for constipation -Gavilax 17 grams, give 17 grams on days other than Monday/Wednesday/Friday PRN for constipation -glycerin suppository 2 grams, give rectally PRN	01750		

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01750	Continued From page 46 for constipation -Tussin DM 100-10, give 10 milliliters (ml) orally PRN for cough or congestion -Robitussin Cough/Chest 10-200 mg/5 ml, give 10 ml PRN for cough The licensee did not provide instruction for the ULP to understand which PRN medication for pain, constipation or cough should be used first, second, etc. R7 R7 was admitted on March 28, 2000, with diagnoses including cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management. On May 6, 2025, at 6:35 a.m., the surveyor observed O/ULP-B provide R7's morning eye drops prior to morning cares. R7's signed medication orders dated November 14, 2024, included one inhaler, one eye drop, one eye ointment, two blood pressure medications, one supplement, one medication for bladder spasms, one for acid reflux, one for depression, one for cholesterol, one for diabetes, one for edema, one for constipation, and one nasal medication. R7's same orders included the following as needed (PRN) medications: two skin barriers, one antifungal topical cream, three for mild pain, one nebulizer for breathing, one topical pain medication, two topical antibiotic ointments, one oral medication for abdominal gas, five for constipation, one for lactose intolerance, one for diarrhea, one for migraine headaches, one for nausea, one for cough, and one for heartburn.	01750		

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01750	Continued From page 47 R7's medication administration record (MAR) dated April 2025, included the following PRN medications: - acetaminophen 500 mg, give two tablets PRN for pain - ibuprofen 200 mg, give two tablets PRN for pain - MAPAP Arthritis 650 mg, give one tablet, every eight hours PRN for pain - Colace 100 mg, give one tablet by mouth PRN for constipation - glycerin suppository 2 grams, give one suppository rectally PRN for constipation - Milk of Magnesia 1200 mg/15 ml, give 30 ml PRN for constipation - Senna 8.6 mg, give two tablets orally PRN for constipation The licensee failed to provide instruction for the ULP to understand which PRN medication for pain or constipation should be used first and second, etc. On May 8, 2025, at 12:00 p.m., LALD-A stated she would review with the RN, the requirement regarding written instructions when multiple PRN medications were used for the same symptoms. She further stated the licensee was not familiar with this requirement. Basaglar manufacturer's instructions dated November 2022, indicated to wipe the insulin pen rubber tip with an alcohol wipe prior to attaching a new needle, and indicated to prime the new needle with 2 units of insulin prior to dialing the dose of insulin to be given. Lispro manufacturer's instructions dated July 2023, indicated to wipe the insulin pen rubber tip with an alcohol wipe prior to attaching a new	01750		

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01750	Continued From page 48 needle, and indicated to prime the new needle with 2 units of insulin prior to dialing the dose of insulin to be given. The licensee's Insulin Pen Procedure dated June 2021, indicated to prepare the insulin pen, remove the pen cap and clean with alcohol wipe, connect the needle to the pen, and prime the pen per manufacturer instructions (see MAR); to remove any air bubbles that may be present. The licensee's Medication and Treatment-Delegation and Administration policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has: -Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -Communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced	01770		

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01770	Continued From page 49 by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for two of two residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 5, 2025, at 11:00 a.m. licensed assisted living director (LALD)-A stated the licensee provided medication management services to their residents, including medication setup. LALD-A stated the licensee used a long-term care pharmacy, but not all medications were pre-packaged in bubble packs and the licensee's nurses set the unpackaged medications in a med-minder (plastic pill box) for staff to administer. R6 R6's Service Plan dated March 13, 2024, indicated he received the service of medication administration and medication set up. R6's signed medication orders dated April 26, 2025, and April 29, 2025, included one oral medication for diabetes, one injection for diabetes, one medication for thyroid, one for gout, one for the heart, two for cholesterol, one for	01770		

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01770	Continued From page 50 heart failure, one for constipation, one for heart rate control, one for mild pain, one for angina, two skin barriers, one topical (on the skin) for rash and three supplements. On May 6, 2025, at 6:25 a.m., the surveyor observed unlicensed personnel (ULP)-D check the electronic medication administration record (EMAR) on the computer, pulled R6's med-minder from the locked medication cart, counted nine tablets as compared to the EMAR and placed them in a medication cup. ULP-D took the medications along with a cup of water to R6 and administered them. R7 R7's Service Plan dated January 1, 2025, indicated he/she received the service of medication administration and medication set up. R7's signed medication orders dated November 19, 2024, included scheduled medications including one inhaler, one eye drop, one eye ointment, two blood pressure medications, one supplement, one medication for bladder spasms, one for acid reflux, one for depression, one for cholesterol, one for diabetes, one for edema, one for constipation, and one nasal medication. R7's same orders included the following as needed (PRN) medications: two skin barriers, one antifungal topical cream, two for mild pain, one nebulizer for breathing, one topical pain medication, two topical antibiotic ointments, one oral medication for abdominal gas, five for constipation, one for lactose intolerance, one for diarrhea, one for migraine headaches, one for nausea, one for cough, and one for heartburn. On May 6, 2025, at 8:15 a.m. during medication cart review, the surveyor observed a med-minder	01770		

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01770	Continued From page 51 box containing pills set up for administration. Owner/unlicensed personnel (O/ULP)-B stated R7's morning medications had already been administered by staff. R6 and R7'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 May 7, 2025, at 10:40 a.m., O/ULP-B stated the registered nurse (RN) only wrote a clinical note indicating she set up medications for the residents in their med-minders. She did not include the above listed required content in her documentation. O/ULP-B further stated this would be the same for all 10 residents. The licensee's Medication Management-Dosage Box Set-up policy dated August 1, 2021, indicated: 1. A licensed nurse will assure the medication orders are properly entered into the Medication Administration Record (MAR) software after receiving them from the pharmacy via the MAR software. 2. This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 3. For medications included in the dosage box, the day and time of administration will be noted in the MAR.	01770		

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01770	Continued From page 52 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01890 SS=D	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 monitor for expired medications and failed to ensure all medications bore a proper label for one of ten 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, 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: On May 6, 2025, at 8:15 a.m., the surveyor reviewed the locked medication storage cart with owner/unlicensed personnel (O/ULP)-B. O/ULP-B observed and confirmed the following findings: -R4's antifungal cream with an expiration date of November 13, 2024;	01890		

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CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HIGHWAY 56 SOUTH BERNE, MN 55985

(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
01890	Continued From page 53 -R4's ketoconazole cream with an expiration date of September 20, 2024; and -R4's hydrocortisone cream lacked a label with the required content The licensee failed to ensure all to ensure all medications had not exceeded their expiration date and failed to ensure all medications bore a proper label. The licensee's Medications-Prescribed-Not Prescribed policy dated August 1, 2021, indicated [licensee name] providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30326	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HIGHWAY 56 SOUTH BERNE, MN 55985

(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
01950	Continued From page 54 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of three residents (R5, R7) 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: R5 R5 diagnoses included type 2 diabetes. R5's Service Plan dated January 3, 2025, included the service of medication administration, blood sugar monitoring, CPAP (continuous positive airway pressure). R5's signed medication orders dated August 23, 2024, included Lispro 100 units/milliliter (u/ml),	01950		

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	30326	A. BUILDING: _____ B. WING _____	05/08/2025

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(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
01950	Continued From page 55 inject 7 units three times daily for diabetes and blood sugar checks four times daily. On May 6, 2025, at 5:40 a.m., the surveyor observed unlicensed personnel (ULP)-D complete R5's morning/before breakfast blood sugar check. R5's Treatment Plan dated January 3, 2025, included blood glucose monitoring and CPAP use. R5's Service Delivery Record dated April 2025, indicated fasting blood sugar checks were completed four times daily, and lacked specific instructions/parameters for blood sugar levels. The licensee's RN did not provide direction regarding the management of R5's blood sugar parameters and when staff should notify the RN. R7 R7 diagnoses included cerebral palsy (a brain injury usually at birth affecting the body). R7's Service Plan dated January 1, 2025, indicated R7 received services including medication management, blood sugar monitoring, suprapubic catheter (a urinary catheter placed through the abdominal wall into the bladder) management, compression wraps, assistance with dressing, grooming, bathing, transfers and repositioning in bed and in wheelchair. On May 6, 2025, at 6:35 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B provide morning cares to R7, including changing R7's urinary bag to a leg bag, providing catheter care/stoma care, applying compression wraps to	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30326	A. BUILDING: _____ B. WING _____	05/08/2025

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(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
01950	Continued From page 56 both lower extremities, dressing, and assisting with dressing and transferring to a wheelchair. O/ULP-B stated R7's blood sugar monitoring was scheduled three times weekly and was not due until the following day. R7's signed prescriber's orders dated November 11, 2024, indicated:; - blood sugar monitoring, twice daily three times per week; -suprapubic catheter 22 french (fr), change as needed (done by medical provider); - ACE wrap (compression wraps), apply to both legs wrapping from foot to ankle, on in the morning and off at bedtime R7's Treatment Plan dated January 1, 2025, included compression wraps, blood sugar monitoring, and catheter management. R7's Service Delivery Record (used to document treatments) dated April 2025, included: - compression wraps (ACE wraps) to both legs wrapped from foot to ankle, on in the morning, off at bedtime. - blood sugar monitoring, check two times daily three times per week - suprapubic catheter management-night bag change to leg bag in the morning, and back to night bag at bedtime, "stoma care" cleansing catheter insertion site) daily. The licensee's RN did not provide direction regarding the management of R7's blood sugar parameters, compression stocking (monitoring for redness/open skin), and suprapubic catheter concerns (cloudy/bloody urine, decreased/no urine output, abdominal pain). On May 8, 2025, at 12:00 p.m., licensed assisted	01950		

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01950	Continued From page 57 living director (LALD)-A stated she was not aware of any written treatment instructions by the nurse for ULP to reference for the above listed treatments and would review further with the nurse. The licensee's Medication and Treatment Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the nurse: -has instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records - communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 58 Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for the licensee's two residents (R1, R2) who both had bed rails. This resulted in an immediate correction order on May 5, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension and type 2 diabetes. R1's Service Plan dated April 12, 2025, indicated R1 received assistance with medication administration, assistance with bathing, dressing, toileting and transferring/repositioning. On May 5, 2025, at 11:45 a.m. during the facility tour, the surveyor noted R1's room to include a consumer type bed rail system. The consumer bedrail system included two legs that slipped between the mattress and box spring. The rail was not securely attached to the bed. Licensed assisted living director (LALD)-A indicated R1 used the rail to assist with transfers from a sitting to standing position or repositioning while in bed. R1's record included a comprehensive	02310		

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02310	Continued From page 59 assessment dated April 15, 2025, which indicated R1 needed/received set-up assistance (pulling back covers, placing assistive equipment near bed) for getting in and out of bed, but R1 was able to get out of bed independently. R1's assessment indicated "N/A" for supporting resources to get in and out of bed. R1's comprehensive assessment lacked any indication a consumer bedrail system was used by R1. R1's record did not include an assessment of her consumer rail, education on the risks and benefits of rail use, manufacturer's instructions, and evidence of safety recall checks, as required. R2 R2's diagnoses included multiple sclerosis, and heart disease. R2's Service Plan dated December 21, 2023, indicated R2 received assistance with medication administration and assistance with bathing. On May 5, 2025, at 10:47 a.m. during the facility tour, the surveyor noted R2's room included an electric bed with a consumer type bedrail. The consumer bedrail included two legs that slipped between the mattress and box spring/lower mattress support. The bedrail was securely fastened to the bed. LALD-A stated R2 used the bedrail to assist with transfers from a sitting to a standing position when getting out of bed. R2's record included a comprehensive assessment dated April 13, 2025, which indicated R2 was independent with transfers and indicated "N/A" for supporting resources for resident getting in and out of bed. R2's comprehensive assessment lacked any evidence the licensee assessed R2's consumer bedrail system/use.	02310		

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02310	Continued From page 60 R2's record did not include an assessment of her consumer rail, education on the risks and benefits of rail use, manufacturer's instructions, and evidence of safety recall checks, as required. On May 5, 2025, at 11:57 a.m., LALD-A stated she had contacted clinical nurse supervisor (CNS)-C and stated CNS-C had not completed an assessment of R1 or R2's consumer bedrail, nor discuss risks verses benefits of bedrail system use, nor had manufacturer's instructions for the bedrails. LALD-A further stated the licensee had not checked for safety recalls. LALD-A stated she was not aware of the consumer bedrail requirements. The licensee's Side Rail Use Policy dated August 1, 2021, indicated when [licensee name] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee name] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

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02310	Continued From page 61 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for	02310		

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02310	Continued From page 62 hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took action on May 5, 2025; however, the scope and level remain at I.	02310		

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

Food & Beverage Inspection Report

Establishment Info

Circle Drive Manor Assisted Living
56733 State Hwy 56 South
West Concord, MN 55985
Dodge County
Parcel:

Phone: 507-527-2424
circledrivemanor@hotmail.com

License Info

License: HDIF 30326
Melissa Christianson
Risk:
License:
Expires on:
CFPM: Melissa Christianson
CFPM #: 14408; Exp: 6/20/2026

Inspection Info

Report Number: F7962251009
Inspection Type: Full - Single
Date: 5/6/2025 Time: 10:52:49 AM
Duration: 90 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: 10:30 chicken salad made and put into domestic refrigerator
11:21 temperature taken, 66 deg, salad in a covered, deep, glass container
staff put into a shallow metal pan during inspection. use above methods to cool
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Domestic refrigerator milk 42.6, orange juice 42.1, staff turned unit down during inspection
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT:
particle board dry storage shelving deteriorating, covered in contact paper
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

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: test strips expired
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

New Order: 6-200 Physical Facility Design and Construction
6-202.15A *Priority Level: Priority 3 CFP#: 38*
MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.
COMMENT: screen in kitchen window torn
Comply By: 5/20/2025 Originally Issued On: 5/6/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.115AB *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.
COMMENT: Do not allow dog access to the kitchen
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: spray bottle of sanitizer 500ppm quaternary ammonia
Comply By: 5/6/2025 Originally Issued On: 5/6/2025

Food & Beverage General Comment

Water test 3-10-25

Facility has an undercounter high temp dish washing machine, cycle takes 2 hours 42 minutes to complete. Facility uses two compartment sink to wash and rinse dishes. Dishes sit on counter until put into dish washing machine to sanitize. I recommend a basin to sanitize the dishes after wash rinse sanitize in two compartment sink.

unit turned down

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 F7962251009 from 5/6/2025

Melissa Christianson
Owner

Heather Flueger,
Public Health Sanitarian 3
507-206-2723
heather.flueger@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

Circle Drive Manor Assisted Living
West Concord
County/Group: Dodge County

Inspection Info

Report Number: F7962251009
Inspection Type: Full
Date: 5/6/2025
Time: 10:52:49 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Greater Than** 500 PPM
Comment:
Violation Issued?: Yes

Minnesota (MDH) Version
EH Manager; RPT: F7962251009

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 5/6/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:52:49 AM
Score (optional)		Dur: 90 min

Establishment:	Address:	City/State:	Zip:	Phone:
Circle Drive Manor Assisted Living	56733 State Hwy 56 South	West Concord, MN	55985	507-527-2424
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HDIF 30326	Melissa Christianson	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/A	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	OUT	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
	Safe Food and Water			
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33	X	Proper cooling methods used; adequate equipment for temperature control		
34	N/A	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38	X	Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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	Proper Use of Utensils			
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
	Utensils, Equipment and Vending			
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: