Electronically Delivered

August 19, 2025

Licensee
Lakeview Assisted Living
941 10 Street
Heron Lake, MN 56137

RE: Project Number(s) SL30568016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30568016-0 On June 30, 2025, through July 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 24 residents; 24 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly 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 included all required content for one of two employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on December 23, 2024, to provide direct care and services to the residents residing within the facility. On June 30, 2025, at 2:40 p.m., the surveyor observed ULP-D administering medications to R10 and R2. ULP-D's employee record included a Baseline TB (tuberculosis) Screening Tool for Health Care Workers dated June 19, 2024. ULP-D's employee record lacked evidence of tuberculosis (TB) testing. On July 2, 2025, at 2:29 p.m., licensed assisted living director (LALD)-A stated ULP-D had originally been hired at a sister facility and began working at this facility on December 23, 2024. LALD-A stated TB testing was not in ULP-D's electronic file and she had contacted the clinic to send her the lab results. The licensee's 8.07 Tuberculosis & Staff Screening policy dated June 17, 2022, read PERSONNEL TB SCREENING: Personnel whose essential job functions require work within the same air space of assisted living residents shall be screened and tested for tuberculosis	0 650		

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0 650	Continued From page 5 prior to the personnel being exposed to clients. Screening shall be conducted as follows: 1. New personnel, to include previous staff that are a rehire, shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (see following form) 2. New personnel, to include previous staff that are a rehire, shall have a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs (see following protocol) 3. No team member shall be permitted to begin work where the work involves sharing the air space with home care clients until the negative results of the first Mantoux are read and documented. 4. The following documented blood tests shall be an acceptable substitute for a two-step Mantoux: QuantiFERON TB-Gold QuantiFERON-TB-Gold InTube T-SPOT 5. Personnel TB screening results shall be kept in each team member file No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	0 700		

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0 700	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. 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: On July 1, 2025, the surveyor made the following observations: The facility had two medication carts, containing laptop computers, sitting in a hallway in the center of the building, near a sitting area for residents and guests. At 7:14 a.m., unlicensed personnel (ULP)-I set up R1's medications while reviewing the resident's medication administration record (MAR) on the laptop computer and setting up medications for administration. ULP-I left the medication cart, went down the hall to R1's room, checked R1's blood sugar and administered the medication. ULP-I did not protect the resident's information on the open laptop prior to leaving the area. At the time, there were two residents sitting in the area. ULP-I returned to the cart at 7:20 a.m.	0 700		

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0 700	Continued From page 7 At 7:26 a.m., ULP-I set up medications for R11 while reviewing the resident's MAR. ULP-I left the medication cart, went down the hall to R11's room and administered medications to R11. ULP-I did not protect the resident's information on the open laptop prior to leaving the area. ULP-I returned to the cart at 7:28 a.m. At 7:32 a.m., ULP-I set up medications for R13 while reviewing the resident's MAR. ULP-I left the medication cart, went down the hall to R13's room and administered medications to R13. ULP-I did not protect the resident's information on the open laptop prior to leaving the area. ULP-I returned to the cart at 7:34 a.m. On July 1, 2025, at 11:25 a.m. clinical nurse supervisor (CNS)-B stated staff should minimize or lock the laptop screen or place a cover over it to protect resident information when they walk away from the laptop. The licensee's 2.38 Resident Records - Information & Content policy dated August 1, 2021, indicated resident records whether written or electronic will be protected against loss, tampering, or unauthorized disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 775		

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0 775	Continued From page 8 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: SMOKE ALARMS During facility tour on July 1, 2025, from 1:06 p.m. through 2:04 p.m., the surveyor entered resident unit 15 with director of maintenance (DM)-H. DM-H tested the smoke alarm and the surveyor observed that the smoke alarm did not operate as designed. DM-H stated the alarms were old and they plan to replace the alarms throughout the facility. During same tour the surveyor observed that the resident unit smoke alarms throughout the facility were yellowed and appeared to be an older style. DM-H stated that the alarms were older than ten years and they plan to replace all the resident unit smoke alarms. State Fire Code in Minnesota Rules, chapter 7511 requires smoke alarms be replaced when they fail	0 775		

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0 775	Continued From page 9 to operate or when they exceed ten years from the date of manufacture. CARBON MONOXIDE ALARMS During same tour the surveyor observed that carbon monoxide alarms or detectors were not provided in the facility. DM-H stated they the detectors located in the maintenance and boiler rooms were smoke and carbon monoxide detectors. Surveyor did not observe anything to indicate the function of these detectors and requested a copy of the annual fire alarm testing and inspection report to verify what type of detectors were located in the maintenance and boiler rooms. DM-H stated they would get the report. During an interview on July 1, 2025, at 2:39 p.m. with DM-H and licensed assisted living director (LALD)-A, the surveyor again requested a copy of the annual fire alarm testing and inspection report. DM-H stated they would email a copy to the surveyor. No further information was received. State Fire Code in Minnesota Rules, chapter 7511 requires either; rooms that contain a fuel burning appliance be equipped with a carbon monoxide detection system, or carbon monoxide alarms be located within ten feet of every sleeping room. LALD-A and DM-H verified the above findings and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 780	Continued From page 10	0 780		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the resident unit to actuate. This deficient condition had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on July 1, 2025, from 1:06 p.m. through 2:04 p.m., the surveyor entered the double resident unit in the NW Wing with director of maintenance (DM)-H. DM-H tested the smoke alarms and the surveyor observed that the two smoke alarms in the unit were not interconnected. DM-H stated the alarms were wireless and needed to be reprogrammed. All resident units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the resident unit. DM-H verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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:	0 810		

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0 810	Continued From page 12 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 1, 2025, at 2:05 p.m., licensed assisted living director (LALD)-A and director of maintenance (DM)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensees FSEP titled "4.70 Fire", dated 6/15/24, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The plan failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.	0 810		

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0 810	Continued From page 14 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. During an interview on July 1, 2025, at 2:39 p.m., LALD-A and DM-H stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member	01530		

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01530	Continued From page 15 must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (unlicensed personnel (ULP)-C, 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). The findings include: ULP-C was hired December 13, 2018, under the	01530		

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01530	Continued From page 16 Comprehensive Home Care license and began providing direct cares and services under the Assisted Living license on August 1, 2021. On June 30, 2025, at 11:19 a.m., the surveyor observed ULP-C administering medications to the residents. ULP-C's record indicated she had completed 0.75 hours of Mental Illness training on August 8, 2020, and repeated the training on November 12, 2022. ULP-C's record did not include the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2024. ULP-D ULP-D was hired on December 23, 2024, and provided direct care and services for the licensee. On June 30, 2025, at 2:40 p.m., the surveyor observed ULP-D administering medications to residents. ULP-D's record indicated he had completed 0.75 hours of Mental Illness training on June 18, 2024. ULP-D's record did not include the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2024. On July 2, 2025, at 4:45 p.m., licensed assisted living director (LALD)-A stated she was unaware the initial training on the new required topics needed to be completed by July 1, 2024, and all staff would have had the same training. The licensee's 10.02 Dementia, Mental Illness, and De-escalation Training policy dated June 23, 2025, indicated 1. All personnel will complete	01530		

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01530	Continued From page 17 eight (8) hours of initial training within 120 hours of the employment start date. 2. All personnel will complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01750 SS=D	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 the resident record specified, in writing, specific instructions for diclofenac gel (pain relief) for one of one resident (R5) and insulin for one of one resident (R6). 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	01750		

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01750	Continued From page 18 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 July 1, 2025, at 8:56 a.m., unlicensed personnel (ULP)-I brought R5 to a conference room with the surveyor and stated he was going to administer diclofenac. ULP-I put on gloves, put some of the diclofenac gel directly onto his gloved hand, put some of the gel on R5's left knee and some on the right knee. ULP-I then rubbed the diclofenac onto the front and back of R5's knees. R5's Service Plan dated June 17, 2025, indicated R5's services included medication administration. R5's June 1-30, 2025, medication administration record (MAR) included: - diclofenac gel one application topically twice daily to bilateral knees. R5's unsigned, After Visit Summary dated December 12, 2024, included diclofenac gel apply to both knees twice daily. The order did not include the dosage. On July 1, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated ULP-I should have measured the diclofenac gel using the measuring strip from the manufacturer. CNS-B further stated the physician's order should have included the dose and specific instructions should have been included on the MAR.	01750		

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01750	Continued From page 19 R6 On July 1, 2025, at 8:21 a.m., the surveyor observed ULP-C administering insulin to R6. ULP-C removed the Novolin 70/30 insulin pen from the medication cart, cleaned the port, put on a pen needle, dialed the insulin pen to 30 units, and administered the insulin. ULP-C did not mix the insulin by rotating the pen up and down 10 times. R6's service plan dated May 30, 2025, indicated R6's service included medication administration. R6's June 1-30, 2025, MAR read "Insulin 70/30 30 units twice daily. "gloves. Remove pen cap. Wipe with alcohol swab. Apply pen needle. If new pen, dial pen to "2", dispose of "2" units. Pen is now primed. Verify pen is back to "0". Dial pen to instructed units per EMAR. Pen is now ready for administration. Clean injection site with alcohol. Dial to 30 units. Inject insulin 30 units with pen at 90 degree angle. Hold for 10 seconds. Remove". The MAR did not include instructions it mix the insulin by rotating the pen up and down 10 times. On July 1, 2025, at 11:07 a.m., CNS-B stated staff should administer medications according to manufacturer guidelines. Staff should have mixed the insulin prior to administration and the instructions should have been included on the MAR. Novolin 70/30 prescribing information dated November 2019, indicated Gently move the pen up and down twenty times between position 1 and 2 as shown, so the glass ball moves from one end of the cartridge to the other (see diagram B). Repeat moving the pen until the liquid appears white and cloudy. For every following injection move the pen up and down between positions 1	01750		

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01750	Continued From page 20 and 2 at least ten times until the liquid appears white and cloudy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medications were secured and locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Medication carts On July 1, 2025, the surveyor made the following	01880		

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01880	Continued From page 21 observations: The facility had two medication carts sitting in a hallway in the center of the building, near a sitting area for residents and guests. There was a locked medication room in the same area. At 6:14 a.m. upon arriving at the facility, the surveyor observed both medication carts unlocked. Unlicensed personnel (ULP)-I went into the laundry room and then into the medication room. The medication carts were not within ULP-I's sight. There was a resident sitting in the area. At 6:16 a.m., ULP-I was removing blood glucose monitors and preparing to complete cares when he was called to a resident room. ULP-I locked the medication cart; however, he left the keys laying on the top of the cart. At 6:22 a.m., ULP-I answered a call light and retrieved water and ice from the kitchen, returned to resident room and gave to them. At 6:32 a.m., ULP-I picked up the keys, At 7:14 a.m., ULP-I set up R1's medications for administration. ULP-I left the medication cart, went down the hall to R1's room, checked R1's blood sugar and administered the medication. ULP-I did not lock the cart and left the keys in the lock on the medication cart. At that time, there were two residents sitting in the same area. ULP-I returned to the cart at 7:20 a.m. and licensed assisted living director (LALD)-A handed ULP-I the keys to the medication cart, stating she had to check on something. The medication cart was locked upon ULP-I's return. At 7:32 a.m., ULP-I set up R13's medications for	01880		

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01880	Continued From page 22 administration. ULP-I left the medication cart, went down the hall to R13's room and administered medications to R13. ULP-I could not see the medication cart from R13's room. ULP-I returned to the cart at 7:34 a.m. Medication refrigerator On July 1, 2025, the following observations were made by the surveyor: At 6:30 a.m., ULP-I took a reusable ice pack from R11, brought it to the medication room. ULP-I used a touch pad to enter a code to open the medication room door. ULP-I entered the room, took a key hanging on the wall and used it to unlock the medication refrigerator. ULP-I placed the ice pack in the freezer, hung the key back on the wall and exited the room. At 7:50 a.m., director of maintenance (DM)-H used the keypad to enter in the code, entered the medication room, was in the room for approximately one minute and then exited the room. At 8:10 a.m., LALD-A entered the medication room and exited with some papers in her hand (key on wall for med fridge) At 10:30 a.m., LALD-A entered the medication room because the printer was in there, and she printed an employee list. Requested fridge temp log. Went into nursing office to make a copy. Sarah was sitting in the med room printing stuff. On July 1, 2025, at 11:25 a.m. clinical nurse supervisor (CNS)-B stated all medications should be stored securely with only medication trained staff having access.	01880		

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01880	Continued From page 23 The licensee's 12.17 Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by the site, medications will be kept securely locked and stored per manufacturer's directions. Only authorized personnel will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=D	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: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R4) with a consumer grab bar. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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	02310		

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02310	Continued From page 24 situation has occurred only occasionally). The findings include: On June 30, 2025, at 2:27 p.m., the surveyor observed R4's bed had a consumer grab bar on his bed. R4's record included manufacturer instructions for the grab bar but lacked evidence the Consumer Product Safety Commission (CSPC) website had been checked for recalls. R4's Bed Safety Assessment dated April 22, 2025, indicated R4 had a consumer grab bar that he used to aid in turning and repositioning in bed. The assessment lacked evidence that the CSPC had been checked for recalls. On July 1, 2025, at 12:02 p.m., clinical nurse supervisor (CNS)-B stated R4's record did not have documentation in his record that CSPC had been checked for recalls. The nurse should have checked the site and documented it on R4's assessment. The MDH website, Assisted Living Resources & FAQs indicated licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information ... 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	02310		

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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
02310	Continued From page 25 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... 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 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

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02320	Continued From page 26 and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice for the licensee's one resident (R5) receiving diclofenac gel (pain relief) for one of one resident (R6) receiving insulin administration, and when one of four unlicensed personnel (ULP)-C did not check the medication administration record (MAR) prior to administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 1, 2025, at 8:56 a.m., ULP-I brought R5 to a conference room with the surveyor and stated he was going to administer diclofenac. ULP-I put on gloves, put some of the diclofenac gel directly onto his gloved hand, put some of the gel on the left knee and some on the right knee. ULP-I then rubbed the diclofenac into the front and back of R5's knees. R5's Service Plan dated June 17, 2025, indicated R5's services included medication administration. R5's June 1-30, 2025, medication administration	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

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02320	Continued From page 27 record (MAR) included: - diclofenac gel one application topically twice daily to bilateral knees. R5's unsigned, After Visit Summary dated December 12, 2024, included diclofenac gel apply to both knees twice daily. The order did not include the dosage. On July 1, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated ULP-I should have measured the diclofenac gel using the measuring strip from the manufacturer. CNS-B further stated the physician's order should have included the dose and specific instructions should have been included on the MAR. R6/ULP-C On June 30, 2025, at 11:19 a.m., the surveyor observed ULP-C administering Novolin insulin and sulcralfate to R6. ULP-C removed the sulcrafate card from the cart and punched a pill into the medication cup. ULP-C removed the insulin pen and blood glucose meter and set up supplies. ULP-C checked the blood sugar and the result was 229. ULP-C stated she knows the resident's medications and insulin so she didn't need to check the MAR, as R6 should get 4 units of insulin. ULP-C then cleaned the port of the insulin pen, placed a pen needle on the pen, dialed the pen to 4 units and administered the insulin. ULP-C then administered the sulcralfate. ULP-C did not check the MAR prior to administering the oral medication or the sliding scale insulin, and ULP-C did not prime the pen per manufacturer instructions. On July 1, 2025, at 8:21 a.m., the surveyor observed ULP-C administering insulin to R6.	02320		

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02320	Continued From page 28 ULP-C removed the Novolog insulin pen, Novolin 70/30 insulin pen, and blood glucose meter from the medication cart. ULP-C checked blood glucose with a result of 169. ULP-C stated R6 gets 2 units of Novolog insulin. ULP-C cleaned the ports of both pens, put on pen needles, dialed the Novolin 70/30 insulin pen to 30 units, and administered the insulin. ULP-C dialed the Novolog insulin pen to 2 units and administered the insulin. ULP-C did not check the MAR prior to administering the medications, did not mix the Novolin 70/30 insulin by rotating the pen up and down 10 times, and did not prime the insulin pens. R6's service plan dated May 30, 2025, indicated R6's service included medication administration. R6's June 1-30, 2025, MAR indicated the following: - Insulin 70/30 30 units twice daily. "gloves. Remove pen cap. Wipe with alcohol swab. Apply pen needle. If new pen, dial pen to "2", dispose of "2" units. Pen is now primed. Verify pen is back to "0". Dial pen to instructed units per EMAR. Pen is now ready for administration. Clean injection site with alcohol. Dial to 30 units. Inject insulin 30 units with pen at 90 degree angle. Hold for 10 seconds. Remove". The MAR did not include instructions it mix the insulin by rotating the pen up and down 10 times. - "Novolin R (Daily) per sliding scale Blood Glucose Reading/Insulin 70-120 = NO INSULIN 121-180 = 2 units 181-240 = 4 units 241-300 = 6 units 301-350 = 8 units 351-400 = 10 units 401-450 = 12 units	02320		

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	30568	A. BUILDING: _____ B. WING _____	07/02/2025

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02320	Continued From page 29 451-500 = call on call provider and follow orders given. 501 and above = ER visit." - sucralfate 1 gram by mouth four times a day. On July 1, 2025, at 11:07 a.m., CNS-B stated staff should always check the MAR before administering medications. Staff should never rely on their memory and should always check the MAR. Novolin 70/30 prescribing information dated November 2019, included the following: - Gently move the pen up and down twenty times between position 1 and 2 as shown, so the glass ball moves from one end of the cartridge to the other (see diagram B). Repeat moving the pen until the liquid appears white and cloudy. For every following injection move the pen up and down between positions 1 and 2 at least ten times until the liquid appears white and cloudy. - Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to make sure you take the right dose of insulin: F. Turn the dose selector to select 2 units. Hold your Novolin 70/30 FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. Novolog prescribing information dated February 2015, includes "Turn the dose selector to 2 units. Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0"	02320		

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02320	Continued From page 30 must line up with the dose pointer. A drop of insulin should be seen at the needle tip." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Lakeview Assisted Living
941 10th Street
Heron Lake, MN 56137
Jackson County
Parcel:

Phone:

License Info

License: HFID 30568

Risk:
License:
Expires on:
CFPM: Alysia Bolstad
CFPM #: CFPM-25175; Exp: 7/30/2026

Inspection Info

Report Number: F1034251047
Inspection Type: Full - Single
Date: 6/30/2025 Time: 11:09:28 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C3 *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

COMMENT: Quaternary ammonium sanitizer coming out of dispenser measured at less than 150 ppm. Ensure concentration is between 200-400 ppm.

Comply By: 6/30/2025 Originally Issued On: 6/30/2025

Food & Beverage General Comment

Inspection conducted in conjunction with HRD.

Discussed order of storage in cooler. Discussed usage of test strips. Should be using quat test strips at least 3 times per week, and using dishwasher thermometer at least 3 times per week.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F1034251047 from 6/30/2025

Alysia Bolstad
Assisted Living Director

McKenna Mathews

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

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Lakeview Assisted Living
Heron Lake
County/Group: Jackson County

Inspection Info

Report Number: F1034251047
Inspection Type: Full
Date: 6/30/2025
Time: 11:09:28 AM

Food Temperature: Product/Item/Unit: Meat**; Temperature Process:** Hot-Holding
Location: Steam Table at 170 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36.1 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

Lakeview Assisted Living
Heron Lake
County/Group: Jackson County

Inspection Info

Report Number: F1034251047
Inspection Type: Full
Date: 6/30/2025
Time: 11:09:28 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Less Than** 150 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 165.1 Degrees F.
Comment:
Violation Issued?: No