



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 30, 2026

Licensee

Mangers Way Home

10652 Alison Way

Inver Grove Heights, MN 55077

RE: Project Number(s) SL35473017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2026
NAME OF PROVIDER OR SUPPLIER MANGERS WAY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 10652 ALISON WAY INVER GROVE HEIGHTS, MN 55077		
(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: SL35473017-0 On August 31, 2026, through September 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five resident(s); five 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 Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1	0 470			
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 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 staffing schedule was posted with the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect all residents, staff, and visitors.	0 470			

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a bed capacity of five residents. At the time of the survey, there were five residents: five receiving services under the Assisted Living with Dementia Care Facility license. During the entrance conference on August 31, 2026, at 1:22 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the staffing shift hours were as follows: Day shift: two unlicensed personnel (ULP) 7:00 a.m. - 3:00 p.m. Evening shift: two ULPs 3:00 p.m. - 11:00 p.m. Night shift: one awake ULP, one sleep ULP 11:00 p.m. - 7:00 a.m. On August 31, 2026, at 2:49 p.m., LALD/RN-A stated the current schedule is posted online and is not currently posted. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective November 3, 2025, the CNS (clinical nurse supervisor) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts,	0 470			

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0 470	Continued From page 3 including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's Staffing policy dated June 29, 2026, indicated a daily staffing schedule is prepared by the house manager and addresses home health aide work schedules for each home health aide showing all work shifts with days/hours worked and the home health aide's resident assignments or work location. The schedule is posted at the beginning of the shift in a central location accessible to staff, residents, volunteers and the public. 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 (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	0 480			

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0 480	Continued From page 4 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 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	0 480			

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0 480	Continued From page 5 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 September 1, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. 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	0 650			

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0 650	Continued From page 6 records must include the following information: (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)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650			

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0 650	Continued From page 7 ULP-C was hired on October 19, 2021, to provide direct care services. On September 1, 2026, at 9:11 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's employee record lacked the documentation of a current annual performance review that identified areas of improvement needed and training needs. On September 3, 2026, at 12:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-C's annual review was waived because he recently trained as the house manager. The licensee's Personnel Records policy dated July 24, 2023, indicated at a minimum, all documents related performance review are kept in the personnel record, as applicable to job requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
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	0 680			

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0 680	Continued From page 8 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency disaster plan with all required content. 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 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 September 1, 2026, at 3:46 p.m., licensed	0 680			

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0 680	Continued From page 9 assisted living director/registered nurse (LALD/RN)-A stated the licensee did not have an emergency preparedness plan that included the following required content: -review and updated annually (dated April 20, 2025); -a current risk assessment for the facility; -review of the missing resident policy at least quarterly; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -review written policies and procedures addressing the facility's EPP (missing a flood policy); -procedure for tracking staff and residents; -volunteers - policy and procedure; and -EP testing/annual testing requirements. The licensee's Emergency Preparedness policy dated July 24, 2026, indicated the licensee will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. The licensee's 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 the assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: -risk assessment and planning -policies and procedures -a communication plan -staff training and exercises/drills No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			

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01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470			

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01470	Continued From page 11 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 the challenges it poses to communication; (2) 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received all orientation to assisted living facility licensing requirements and regulations before providing 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 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).	01470			

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01470	Continued From page 12 The findings include: ULP-C was hired on October 19, 2021, to provide direct care services. On September 1, 2026, at 9:11 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's employee record lacked the following required orientation content: -overview of Assisted Living statutes; -handing of resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of Assisted Living services the employee will provide and provider's scope of license On September 1, 2026, at 3:46 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-C had not completed assisted living orientation as this was missed. The licensee's Staff Orientation and Education policy dated July 24, 2023, indicated all staff providing assisted living through the licensee will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent toto the needs of the residents and would include all the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			

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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
01500	Continued From page 13	01500			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) completed all required annual training topics for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on October 19, 2021, to provide	01500			

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01500	Continued From page 15 direct care services. On September 1, 2026, at 9:11 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's record lacked evidence that ULP-C had completed the following annual training in the last 12 months of employment: -review of provider's policies and procedures On September 1, 2026, at 3:46 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-C did not complete all the required annual training as listed above. The licensee's Staff Orientation and Education policy dated July 24, 2023, indicated that all staff providing assisted living service will complete at least eight hours of education for every 12 months of employment. This would include review of the organization's policies and procedures related to provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide	01540			

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01540	Continued From page 16 direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received required mental illness and de-escalation training in the required time frame for one of one employee (unlicensed personnel (ULP)-C). 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: The licensee had an Assisted Living with	01540			

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01540	Continued From page 17 Dementia Care license. ULP-C was hired on October 19, 2021, to provide direct care services. On September 1, 2026, at 9:11 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's record employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. On September 1, 2026, at 3:46 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-C was not in compliance with mental illness or de-escalation as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640			

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01640	Continued From page 18 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the facility to document agreement on the services to be provided for one of one resident (R2). 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 situation has occurred only occasionally). The findings include: R2 was admitted on December 20, 2023, with a diagnosis that included diabetes. On September 1, 2026, at 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications. R2's Service Plan dated December 20, 2023,	01640			

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01640	Continued From page 19 lacked signature or other authentication by the facility documenting agreement on the services to be provided. On September 1, 2026, at 4:32 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2's service plan lacked a signature by the facility as required. The licensee's Service plan policy dated July 24, 2023, indicated the initial service plan and any revisions are signed by a representative from the license and the resident or resident's representative, indicating agreement with the service to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730			

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01730	Continued From page 20 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 reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01730			

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01730	Continued From page 21 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: R2 was admitted on December 20, 2023, with a diagnosis that included diabetes. On September 1, 2026, at 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications. R2's Service Plan dated December 20, 2023, indicated R2 received services including assistance with medication administration. R2's record lacked a medication management plan to include: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel On September 1, 2026, at 4:32 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2's medication management plan was missing required content as identified above, and it will be added to R2's medication management plan.	01730			

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01730	Continued From page 22 The licensee's Service Plan for Medication Management policy dated July 24, 2023, included the written Medication Management Plan includes the following provisions: -a description of the storage of medications based on the resident assessment* and addressing resident preference, risk of diversion, instructions per manufacturer, documentation procedures, procedures for medication reconciliation* -identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely -description of medication management tasks to be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01730			
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 medications were stored securely for all residents with medication management services. This had the potential to affect the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a	01880			

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01880	Continued From page 23 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 September 1, 2026, at 8:51 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's morning medications. The surveyor observed the magnet key to the facility medication cupboard stored just under a shelf in the main living area where ULP-D obtained the key to open medication cupboard. The cupboard contained multiple medications prescribed to residents of the licensee and was available to the residents, staff, and visitors. On September 1, 2026, 9:52 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the medication magnet key was stored under a shelf in the main living area; however, would now have the medication staff carry the magnet key on them during their shift. The licensee's Storage/Control of Medications policy dated July 24, 2023, indicated that when medications are managed and stored by the licensee, medications will be kept securely locked and only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include on the service plan a written statement of all the treatment or therapy services provided for one of one resident (R2)	01940			

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01940	Continued From page 25 receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on December 20, 2023, with a diagnosis that included diabetes. R2's services delivered record for August 2026, indicated R2 received blood glucose checks as needed, range of motion, and wound care. R2's Service Plan dated December 20, 2023, lacked a written statement of the treatment or therapy services of assistance with blood glucose checks as needed, range of motion, and wound care. On September 1, 2026, at 4:32 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2's service plan did not include the treatment services as listed above and that R2's service plan needed to be updated. The licensee's Treatment and Therapy Management policy dated July 24, 2023, indicated that the licensee will use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. The RN or licensed health professional is responsible for assessing and	01940			

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01940	Continued From page 26 developing the treatment and/or therapy service plan for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2026
NAME OF PROVIDER OR SUPPLIER MANGERS WAY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 10652 ALISON WAY INVER GROVE HEIGHTS, MN 55077			
(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
02240	Continued From page 27 Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for one of one resident (R2). 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 of the residents). The findings include: R2 was admitted on December 20, 2023, with a diagnosis that included diabetes. On September 1, 2026, at 9:11 a.m., the surveyor	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2026
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02240	Continued From page 28 observed unlicensed personnel (ULP)-C administer R2's morning medications. R2's record did not contain written acknowledgement of receipt of the current Assisted Living Bill of Rights (BOR) dated January 1, 2026. On September 1, 2026, at 3:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2's BOR was provided and acknowledged prior to the change on January 1, 2026, and did not get updated yet. This would include all the licensee's residents prior to January 1, 2026, update. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

MANGERS WAY HOME
10652 Alison Way
inver grove heights, MN 55077
Dakota County
Parcel:

Phone:

License Info

License: HFID 35473

Risk:
License:
Expires on:
CFPM: Kfir Batiller
CFPM #: CFPM-18784; Exp:
7/26/2029

Inspection Info

Report Number: F1039261240
Inspection Type: Full - Single
Date: 9/1/2026 Time: 10:45 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-400A Destroying Organisms: cooking time/temperature, freezing

3-401.11A1A Priority Level: Priority 1 CFP#: 18

MN Rule 4626.0340A Cook raw eggs that are broken and prepared in response to the consumer's order and for immediate service to 145 degrees F (63 degrees C) or above for 15 seconds.

COMMENT: COOKED EGG MEASURED 131 DEGREES AT YOKE. INSTRUCTED STAFF TO RE-COOK TO COMPLY WITH ABOVE RULE. EGG MEASURED 151 DEGREES F AFTER RE-COOKING.

Comply By: Complied On Site Originally Issued On: 9/1/2026

Food & Beverage General Comment

CHEESE - COLD COLD, COOLER - 40 DEGREES F
FREEZER - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Jenn Panitzke.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and stone countertops, wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. By log sheet from UST thermometer measurement, dishwashing machine rinse temperature is greater than 160 degrees F.

Verified hand sink correctly set-up, handwashing, gloves, illness policy, probe thermometer.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, vomit/fecal matter clean-up, sanitizing, order on this report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans

Report Number: F1039261240

Inspection Type: Full

Date: 9/1/2026

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and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039261240 from 9/1/2026



Lois Goss
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us