Electronically Delivered

October 15, 2025

Licensee
A Janesville Senior Living LLC
543 Oakwood Drive
Janesville, MN 56048

RE: Project Number(s) SL32938016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in 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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32938	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32938016-0 On September 8, 2025, through September 11, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. 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, 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 had an Assisted Living with Dementia Care license effective November 7, 2024. The licensee's "Provisional Assisted Living Licensure Information and Application", section titled "Official Verification of Owner or Authorized Agent", (page 17 and 18 of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn.	0 420		

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0 420	Continued From page 2 Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page 18 was electronically signed by the authorized agent on May 23, 2024. As a result of this survey, the following orders were issued under 0470, 0480, 0485, 0660, 0680, 0730, 0775, 0790, 0800, 0810, 1500, 1540, 1620, 1640, 1890, 1940, 2110, 2140, 2310, 2320, 2410, 3090 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
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	0 470		

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0 470	Continued From page 3 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 observation, interview, and record review, the licensee failed to ensure the staffing plan was reviewed twice per year. In addition, 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. 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	0 470		

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0 470	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a bed capacity of 26 residents. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license. STAFFING PLAN During the entrance conference on September 8, 2025, at 10:46 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee did not have a staffing plan that was reviewed twice yearly. The current staffing plan provided was dated as reviewed July 8, 2024. LALD-A and CNS-B both indicated they were newly employed and had "not gotten to that yet." DAILY STAFF SCHEDULE POSTING During the entrance conference on September 8, 2025, at 10:46 a.m., LALD-A and CNS-B stated the staffing shift hours were as follows: Day shift: two unlicensed personnel (ULP)- 7:00 a.m. - 3:30 p.m., one ULP 6:30 a.m. - 3:00 p.m. Evening shift: two ULP 3:00 p.m. - 11:30 p.m., one ULP 4:00 p.m. - 10:00 p.m. Night shift: Two ULP 11-7:30 a.m., one ULP 10:00 p.m.- 6:30 a.m. On September 8, 2025, at 11:45 a.m., the surveyor observed the daily staff schedule on a	0 470		

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0 470	Continued From page 5 white board in the front entrance. The staff schedule included how many ULP were working for the AM, PM, and overnight shift; the schedule did not indicate the specific times of each shift and did not identify the direct-care staff member's work location. On September 8, 2025, at 1:48 p.m., CNS-B stated the posted schedule did not include the times of each shift or work location of staff. CNS-B indicated he was not aware of the posting requirement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective January 13, 2025, the CNS 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, 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, Direct-Care Staffing Plan & Daily Schedule policy dated reviewed May 13, 2023, noted the staffing plan would be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year. The 24-hour daily staffing schedule will include: -Direct-care staff work schedules for each direct-care staff member -Indication of all work shifts, including days and hours worked	0 470		

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0 470	Continued From page 6 -Identify direct-care staff member's resident assignments or work location. 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 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	0 480		

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0 480	Continued From page 7 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 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	0 480		

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0 480	Continued From page 8 portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 8, 2025, 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		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 485		

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0 485	Continued From page 9 licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On page four of the licensee's Resident Agreement (assisted living contract), Section 6 Meal Plans included: The community offer the meal plans described on Addendum C. You are not required to select a meal plan to live at the community. The cost of your meal plan, should you select one, is not included in your monthly base fee. Meal plans are available for the additional fees listed on Addendum C. If you wish to change meal plans at any time, you may do so by signing and dating a new meal plan options selection form (Addendum C), which will become part of this agreement and placed in your resident file. Residents on medical assistance programs will need to follow the parameters outlined in the program they are on. The licensee's Addendum C: Meal Plan Options (part of the assisted living contract) indicated residents could choose to participate in: Option 1- three meals a day plus two snacks for $9.00/day	0 485		

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0 485	Continued From page 10 Option 2- no meal plan. The Meal Plan Addendum lacked an option for residents to opt out of payment for one or two meals residents would not want. On September 10, 2025, at 11:14 a.m., licensed assisted living director (LALD)-A stated the same assisted living contract was used for all residents and did not offer residents to opt out of one or two meals the resident would not want. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee (unlicensed personnel (ULP)-D). 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated September 2, 2025, indicated the licensee was a "low risk." ULP-D had a hire date of November 6, 2024. ULP-D's record included a TB symptom screen dated November 6, 2024. The record lacked evidence of TB testing upon hire or within 90 days prior to hire. On September 10, 2025, at 2:30 p.m., staffing coordinator (SC)-F said ULP-D told her she brought a copy from a previous employer and gave it to a nurse who is no longer employed at the facility. SC-F and clinical nurse supervisor (CNS)-B stated ULP-D's record did not include evidence TB testing had been completed upon	0 660		

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	32938	A. BUILDING: _____ B. WING _____	09/11/2025

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0 660	Continued From page 12 hire or within 90 days of hire. "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's TB Prevention and Control policy dated July 14, 2021, indicated prior to contact with clients, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay (IGRA) will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. The licensee's Personnel Records policy dated, indicated the personnel record for each person would include: g. TB screening results No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 13 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680		

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0 680	Continued From page 14 or has the potential to affect a large portion or all the residents). The findings include: The licensee's EP plan consisted of several documents and policies in a red three-ringed binder dated reviewed August 20, 2025. The book included various policies/procedures related to weather events, water shortage, fire, missing person, and a bomb threat. The licensee lacked a customized EP plan to include the following required content: - A description of the population served by licensee and succession planning; - A process for EP collaboration with State and local EP officials/organizations; - Development of additional policies/procedures for: - Subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - Policy/procedure for tracking staff and residents; - Policy/procedure to address safe evacuation from the facility to include (transportation and identification of evacuation location(s); - Policy/procedure for sheltering in place; - Policy/procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secure/maintains availability of records; - Policy/procedure to address use of volunteers, including the process/role for integration; - Policy/procedure to include pre-arranged transfer agreements with other facilities; - Policy/procedure to address role of facility under a waiver declared by the Secretary in accordance	0 680		

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0 680	Continued From page 15 with section 1135 of the Act; - Communication plan that includes contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - Communication plan that includes methods for sharing information for residents under the facility's care, as necessary, with other health providers to maintain continuity of care; - Communication plan that includes a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; - Method for sharing info/notifications with family; On September 10, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A reviewed the EP plan and stated the above required topics were missing. LALD-A stated he was newly employed and had recognized things were lacking in the EP plan but had not been able to get things in place yet. The licensee's Emergency and Disaster Preparedness policy dated reviewed July 30, 2024, noted the facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R 483.73(c). Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified	0 680		

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0 680	Continued From page 16 Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 17 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). 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: R3 began receiving services on May 10, 2022, and was discharged on September 4, 2025.	0 730		

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0 730	Continued From page 18 R3's record included a face sheet and progress note dated September 5, 2025, at 9:09 a.m., identified as the discharge summary. R3's record lacked a discharge summary to include: - courses of illnesses; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status; - a post-discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge plan must indicate where the resident plans to reside, any arrangement that have been made for the resident's follow-up care, and any post-discharge medical and nonmusical services the resident will need. On September 8, 2025, at 3:20 p.m., clinical nurse supervisor (CS)-B stated R3's record lacked the required components as noted above. CS-B indicated he was not aware of the requirement. The licensee's Discharge Summary policy dated reviewed July 30, 2024, noted the discharge summary would include, if applicable, a summary of the resident's stay, including: - Diagnosis - Course of illnesses - Allergies - Treatments - Therapies	0 730		

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0 730	Continued From page 19 - Pertinent lab, radiology, and consultation results - Final summary of the resident's status. The summary will be based upon the latest assessment or review and,if applicable, will include resident status including baseline and current mental, behavioral and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient conditions have the ability to affect all staff and 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 775		

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0 775	Continued From page 20 On a facility tour on September 8, 2025, between 12:30 p.m. and 2:30 p.m. with the licensed assisted living director (LALD)-A, the surveyor observed the following conditions: KITCHEN HOOD CLEANING: The surveyor observed that the kitchen hood grease filters were very greasy. The LALD-A stated they did not know when the last time the kitchen hood and ventilation system was cleaned. The filters and ventilation system must be cleaned by a competent person at intervals so that grease does not accumulate, a minimum of once a year. This cleaning shall be documented. SPECIAL LOCKING: The surveyor observed keyed locks at all doors. The LALD-A did not know what the switches were for nor did they have a key to test. The 2nd floor dementia care area shall have a switch that unlocks the doors on the 2nd floor. This shall be the same for the 1st floor if the SW magnetic lock remains in place and operational. These doors shall also open during power loss and under fire alarm conditions and this shall be tested and verified. FIRE DOORS: The surveyor observed that there were several fire rated doors throughout the facility that did not close and latch under their own power. (2nd floor door to spa, garage door, 1st floor SW door to under steps) These doors shall close and latch under their own	0 775		

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0 775	Continued From page 21 power. Also, the 2nd floor elevator door was propped open with a wedge. This door shall always remain closed or can be held open by a magnetic hold connected to the fire alarm system. MAIN ELECTRICAL PANEL: The surveyor observed that the main electrical panel on the west side of the building was damaged and had a tarp over it. The panel shall be fixed by a qualified/licensed electrician. CARBON MONOXIDE: The surveyor did not observe any carbon monoxide protection the building. Carbon monoxide protection to meet the state fire code shall be installed. The deficient conditions were visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 790 SS=A	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

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0 790	Continued From page 22 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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: On a facility tour on September 8, 2025, between 12:30 p.m. and 2:30 p.m. with the licensed assisted living director (LALD)-A, the following deficient condition was observed: The surveyor observed the fire extinguisher in the elevator equipment room had not had the required annual inspection completed since 2019. Fire extinguishers shall be serviced annually by a competent person. The deficient condition was visually verified by the LALD-A on the tour.	0 790		

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0 790	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 24 On a facility tour on September 8, 2025, between 12:30 p.m. and 2:30 p.m. with the licensed assisted living director (LALD)-A, the surveyor observed the following conditions: WATER DAMAGE/MOLD: The surveyor observed water stains and mold on the gypsum board in the fire sprinkler riser room. The deficient conditions were visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 25 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a memorandum of understanding for transportation or relocation, document required fire safety evacuation training for employees and residents or provide documentation of the required fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or rep-resent a systemic failure that has affected or has the potential to affect a large portion or all of the resi-dents). The findings include: A record review and interview were conducted on September 8, 2025, at approximately 2:30 p.m. with the licensed assisted living director (LALD)-A	0 810		

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0 810	Continued From page 26 on the fire safety and evacuation plan training records for the employees and the residents, fire drills and the fire safety and evacuation plan. TRAINING: Training for the employees and residents on the fire safety and evacuation plan was not being conducted. This shall be completed at new hire and twice a year thereafter for employees and at intake and once a year thereafter for residents. This shall be documented. FIRE DRILLS: Fire drills were not being conducted. Fire drills shall be twice per year on each shift and shall be documented. FIRE SAFETY EVACUATION PLAN: The fire safety evacuation plan did not have a memorandum of understanding for transportation or relocation if the facility needed to be evacuated. The deficiencies noted above were verified by the LALD-A. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01500		

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01500	Continued From page 27 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. 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	01500		

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01500	Continued From page 28 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began providing assisted living services on March 19, 2024. ULP-E's employee record lacked documented evidence of the following required annual training:	01500		

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01500	Continued From page 29 - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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; - 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; - Review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 10, 2025, at 3:15 p.m., licensed assisted living director (LALD)-A stated ULP-E's employee filed lacked the required annual training as noted above. The licensee's Assisted Living or Assisted Living with Dementia Care Annual Training policy dated reviewed July 30, 2024, identified all assisted living employees would complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557.	01500		

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01500	Continued From page 30 b. Assisted living bill of rights. c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill or rights. d. Infection control techniques used in the home and implementation of infection control standard. e. Effective approaches for problem solving when working with challenging behaviors. f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders. g. Review of policies and procedures relating to the provision of assisted living services and how to implement them. h. Principles of person-centered planning and service delivery applies to direct support services provided by staff. i. How person-centered planning and service delivery applies to direct support services provided by staff. j. Emergency and disaster training. The licensee's Personnel Records policy dated reviewed July 30, 2024, noted the personnel record for each person would include: d. Record of required in-service education for all staff providing services to residents, including annual trainings and infection control training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least	01540		

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01540	Continued From page 31 eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D and ULP-E) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01540		

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01540	Continued From page 32 The findings include: The licensee provided services under an Assisted Living Facility with Dementia Care (ALFDC) license. ULP-D ULP-D was hired on November 6, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record contained evidence of completing eight hours of dementia training within 80 hours of work; however, ULP-D's employee record lacked evidence of completing any mental illness, and de-escalation training. ULP-E ULP-E was hired on March 19, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence the employee received evidence of completing any mental illness, and de-escalation training. In addition, ULP-E's employee record lacked evidence of completing two hours of dementia care training annually as required. On September 10, 2025, at 2:20 p.m., staffing coordinator (SC)-F reviewed ULP-D and ULP-E's employee record and stated ULP-D and ULP-E had not completed the required training as noted above. SC-F stated she assigns the training but was not aware of any mental illness or de-escalation training requirements indicating none of the licensee's staff would have this completed.	01540		

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01540	Continued From page 33 The licensee's Assisted Living with Dementia Care Dementia Training policy dated reviewed July 30, 2024, indicated direct-care employees would have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620		

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01620	Continued From page 34 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01620		

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01620	Continued From page 35 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's unsigned, Service Plan with a print date of September 9, 2025, indicated R1 received services including bathing, assistance with TED (thrombo-embolic deterrent) compression stockings, dressing, dressing, grooming, behavior interventions, toileting, blood sugar checks, and medication administration. R1's record included assessments dated June 21, 2024, September 19, 2024, and November 7, 2024. R1's record lacked evidence of additional comprehensive nursing assessments after the November 7, 2024, assessment had been completed. R2 R2's unsigned, Service Plan with a print date of September 9, 2025, indicated R2 received services including bathing, dressing, grooming, ambulation, bed mobility, transfers, toileting, medication administration, assistance with TED compression stockings, weighted utensils, minced and moist food with nectar thickened fluids. R2's record included assessments dated May 15, 2024, August 13, 2024, and November 11, 2024. R2's record lacked evidence of additional comprehensive nursing assessments after the November 11, 2024, assessment had been completed. On September 9, 2025, at 2:50 p.m., clinical	01620		

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01620	Continued From page 36 nurse supervisor (CNS)-B stated R1 and R2's assessments were late as noted above. CNS-B stated he had recently become aware of the assessment schedule requirement and was trying to get caught up. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated reviewed July 30, 2024, noted: 7. Ongoing monitoring and review will be conducted as needed based on changes in the resident needs and will not exceed 90 calendar days from the last review date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 37 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included diabetes. R1's unsigned, Service Plan with a print date of September 9, 2025, indicated R1 received services including bathing, assistance with TED (thrombo-embolic deterrent) compression stockings, dressing, dressing, grooming, behavior interventions, toileting, blood sugar checks, and medication administration. However, the service plan lacked a signature or other authentication by the licensee and the resident/resident's	01640		

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01640	Continued From page 38 representative, documenting agreement on the services to be provided. R2 R2's diagnoses included Parkinson's disease. R2's unsigned, Service Plan with a print date of September 9, 2025, indicated R2 received services including bathing, dressing, grooming, ambulation, bed mobility, transfers, toileting, medication administration, assistance with TED compression stockings, weighted utensils, minced and moist food with nectar thickened fluids. However, the service plan lacked a signature or other authentication by the licensee and the resident/resident's representative, documenting agreement on the services to be provided. On September 9, 2025, at 2:58 p.m., clinical nurse supervisor (CNS)-B stated both R1 and R2's service plans lacked authentication. CNS-B stated some of the current residents have service plans signed by the resident and the licensee, and some would be missing if a revision had occurred, indicating he had recently learned of the requirement. The licensee's Contents of Service Plans policy dated reviewed July 30, 2024, noted service plans and any revisions to service plans will have a signature or other authentication by the licensee and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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01640	Continued From page 39 (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order and failed to ensure time sensitive medications had an opened date for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes. R1's unsigned, Service Plan with a print date of September 9, 2025, indicated R1 received services including medication administration. R1's prescriber orders dated September 8, 2025,	01890		

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	32938	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

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01890	Continued From page 40 included an order for: - Lantus SoloStar (long-acting insulin) inject 16 units subcutaneously BID (twice daily) R1's medication administration record (MAR) dated September 2025, included the medication as ordered above. On September 9, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-E administer insulin to R1. The Lantus SoloStar insulin pen had a label that directed to administer 15 units twice daily. When interviewed at this time, ULP-C stated the label for R1's insulin did not match the MAR but said she would follow the MAR instead of the label. In addition, the surveyor noted there was no date when opened on R1's Lantus SoloStar insulin pen. ULP-E stated R1's insulin pen label should match the order and lacked a date when opened. On September 9, 2025, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated the prescription label should match the current prescriber orders and MAR or have a sticker on the label to alert staff of the new order. CNS-B further stated insulin should be dated when opened. The Lantus SoloStar manufacturer instructions for use dated revised December 2020, indicated once you take your SoloStar out of cool storage, you can use it for up to 28 days. The licensee's Delegation of Nursing Tasks policy dated reviewed July 30, 2024, indicated a registered nurse (RN) may delegate medication administration to unlicensed personnel only after the RN has ensured: -The medication is in the original pharmacy-dispensed container with a proper	01890		

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01890	Continued From page 41 label and directions, in the original over-the-counter container, or the medication has been removed from the original container and placed in a unit container by a licensed nurse. The licensee's Storage of Medications policy dated reviewed July 30, 2025, indicated medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 42 (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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the entrance conference on September 9, 2025, at 10:46 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to their residents, including modified diets and blood sugar checks. R1 On September 9, 2025, at 7:30 a.m., the surveyor	01940		

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01940	Continued From page 43 observed unlicensed personnel (ULP)-C check R1's blood sugar. R1's diagnoses included diabetes. R1's unsigned Service Plan with a print date of September 9, 2025, indicated R1 received services including blood sugar checks. R1's prescriber orders dated September 6, 2025, included an order to check blood glucose three times daily. R2 On September 8, 2025, at 12:04 p.m., the surveyor observed R2 feeding himself cut-up food in the dining room, using weighted silverware and nectar thick fluids (flows slowly off a spoon but still be sipped through a straw or from a cup). R2's diagnoses included Parkinson's disease and dysphagia (difficulty swallowing). R2's unsigned Service Plan with a print date of September 9, 2025, indicated R2 received services including weighted utensils, minced and moist food with nectar thickened fluids. R2's prescriber orders dated September 6, 2025, included an order for nectar thickened liquids. R1 and R2's record lacked a treatment or therapy management plan to include the following: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On September 9, 2025, at 3:14 p.m., CNS-B	01940		

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01940	Continued From page 44 stated R1 and R2's record lacked a treatment management plan to include all the required content as noted above. CNS-B stated R1 was fragile with her diabetes, and parameters should be noted for when to call the nurse. In addition, he would want to know if R2 was having any changes or increase difficulty in swallowing. The licensee's Individualized Medication, Treatment & Therapy Management Plan policy dated reviewed July 30, 2024, noted for each resident receiving treatment management services, the treatment management plan would include: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;	02110		

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02110	Continued From page 45 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in for two of two residents (R1, R2) who resided in an assisted living with dementia care facility. 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	02110		

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02110	Continued From page 46 or has potential to affect a large portion or all the residents). The findings include: The licensee held an Assisted Living with Dementia Care license effective through November 16, 2025, and was licensed for a bed capacity of 26 residents. R1 and R2's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limited the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of resident's possessions.	02110		

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02110	Continued From page 47 On September 10, 2024, at 11:33 a.m., clinical nurse supervisor (CNS)-B stated the dementia care policies had been developed but not provided to the residents. CNS-B indicated he was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. 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) and was issued at a	02140		

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02140	Continued From page 48 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license effective November 7, 2024. During the entrance conference on September 8, 2025, at 10:46 a.m., clinical nurse supervisor (CNS)-B stated he oversaw the staff training in the care of individuals with dementia. CNS-B stated he had completed dementia training for care providers through Crisis Prevention Institute. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed, and Crisis Prevention Institute was not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On September 8, 2025, at 3:10 p.m., CNS-B stated he was unaware the Crisis Prevention Institute training did not meet the requirement according to the approved list provided by the commissioner. The licensee's Assisted Living with Dementia Care Dementia Training policy dated reviewed July 30, 2024, indicated persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia including: - Two years of work experience related to	02140		

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02140	Continued From page 49 Alzheimer's disease or other dementia's or in health care, gerontology, or another related field; - Completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02310 SS=F	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 ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R2) with a bed rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02310		

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02310	Continued From page 50 The findings include: R1's diagnoses included Parkinson's disease, weakness, abnormalities of gait and mobility, and repeated falls. On September 9, 2025, at 9:03 a.m., the surveyor observed R2 in his room. A hospital bed with a right upper side rail was present. R2 indicated he used the rail to help with bed mobility. R2's unsigned Service Plan with a print date of September 9, 2025, indicated R2 received services including bathing, dressing, grooming, ambulation, bed mobility, transfers, toileting, medication administration, assistance with TED (thrombo-embolic deterrent) compression stockings, weighted utensils, minced and moist food with nectar thickened fluids. R2's Side-Rail Use Assessment Form dated July 30, 2025, indicated R2 utilized a hospital bed with side rails to enable and promote independence. It also indicated R1/family had been educated on the risks and benefits of using side rails; however, the assessment lacked measurements of the side rails zones one through four. On September 9, 2025, at 3:16 p.m., clinical nurse supervisor (CNS)-B stated he had not measured R2's side rails and further indicated he had not done measurements for any residents who utilized a hospital bed with side rails. The Food and Drug Administration's (FDA), A Guide to Bed Safety dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The	02310		

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02310	Continued From page 51 FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) identified for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Devices and Device Assessment policy dated reviewed February 1, 2024, indicated devices would be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	02310		

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02310	Continued From page 52 days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of one unlicensed personnel (ULP-C) observed during insulin administration. 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: R1's diagnoses included diabetes. R1's unsigned Service Plan with a print date of September 9, 2025, indicated R1 received services including medication administration.	02320		

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02320	Continued From page 53 R1's prescriber orders dated September 6, 2025, and September 8, 2025, respectively, included orders for: - Humalog KwikPen (fast-acting insulin) inject 16 units subcutaneously with breakfast plus sliding scale: 131-160= 1 unit, 161-190= 2 units, 191-220= 3 units, 221-250= 4 units, 251-280= 5 units, 281-310= 6 units, 311-340= 7 units, 341-370= 8 units, >371= 9 units and notify provider. - Lantus SoloStar (long-acting insulin) inject 16 units subcutaneously BID On September 9, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-C administer Lantus SoloStar (long-acting insulin) and Humalog KwikPen (fast-acting insulin) to R1. ULP-C removed the cap from R1's Lantus SoloStar and Humalog KwikPen and applied a new needle. ULP-C did not use an alcohol prep pad to cleanse the port of the pen before applying the needle. ULP-C dialed the insulin to the prescribed amount, then brought the insulin to R1 in the dining room and administered. ULP-C did not prime the pen with two units of insulin prior to administrating the insulin dose. Immediately following the observation, the surveyor asked ULP-C if she ever utilized alcohol to cleanse the port of the insulin pen prior to applying the needle, and also about priming the pen with two units of insulin prior to dialing the insulin dose. ULP-C stated she had not been trained to do that. On September 9, 2025, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated he trains staff to rub an alcohol swab on the port of insulin pens prior to applying the needle and to prime the insulin pen with a 2-unit waste prior to dialing the prescribed dose.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32938	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

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02320	Continued From page 54 The manufacturer's Lantus SoloStar Instructions for Use revised December 2020, indicated: Step 1: Check the insulin B. Take off the pen cap Step 2: Attach the needle A. Wipe the rubber seal with alcohol B. Removed the protective seal from a new needle C. Line up the needle with the pen, and keep it straight as you attach it Step 3: Perform a Safety test Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly and removes air bubbles. A. Select a dose of 2 units by turning the dosage selector B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. Step 4: Select the dose Step 5: Inject the dose The manufacturer's Humalog KwikPen Instructions for Use revised March 31, 2020, indicated: Step 1: Pull the Pen Cap straight off. Wipe the Rubber Seal with an alcohol swab Step 4: Select a new needle. Pull off the paper tab from the outer needle shield.	02320		

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02320	Continued From page 55 Step 5: Push the capped needle straight onto the pen and twist the needle on until it is tight. Prime before each injection - Priming you pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. - If you do not prime before each injection, you may get too much or too little insulin. Step 7: To prime your pen, turn the dose knob to select 2 units Step 8: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 9: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in	02410		

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02410	Continued From page 56 the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, one of one unlicensed personnel (ULP-C) failed to provide privacy for R1 during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes. R1's unsigned Service Plan with a print date of September 9, 2025, indicated R1 received	02410		

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02410	Continued From page 57 services including medication administration. On September 9, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-C administer Lantus SoloStar (long-acting insulin) and Humalog kwikpen (fast-acting insulin) to R1. After preparing the insulin for administration, ULP-C brought the insulin pens into the dining room where R1 was seated with three other residents (R4, R5, R6) during the breakfast meal. ULP-C informed R1 that she would be administering her insulin, then raised the bottom of R1's shirt exposing part of the resident's abdomen. ULP-C administered both insulins into R1's abdomen then returned to the medication cart. On September 9, 2025, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated staff should not be administering insulin in the dining room in front of other residents as this could be a dignity and infection control issue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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03090	Continued From page 58 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The finding include: On September 8, 2025, at 11:45 a.m., the surveyor observed the front entrance and entryway of the facility. No posting for electronic monitoring was observed. On September 8, 2025, at 3:45 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a posting regarding electronic monitoring. LALD-A indicated he was newly employed and had not noticed it was missing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

A JANESVILLE SENIOR LIVING LLC
543 OAKWOOD DRIVE
Janesville, MN 56048
Waseca
Parcel:

Phone:

License Info

License: HFID 32938

Risk:
License:
Expires on:
CFPM: Karen Beltel
CFPM #: 119288; Exp: 10/5/2026

Inspection Info

Report Number: F1033251168
Inspection Type: Full - Single
Date: 9/8/2025 Time: 11:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 4
Total Priority 3 Orders: 4
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: Raw shelled eggs are stored above ready to eat pudding.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12B *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.
COMMENT: Staff use a cup to scoop sugar and coffee grounds.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Whipped butter containers are stored at room temperature on the counter in the kitchen. Person in charge discarded containers.
Comply By: Complied On Site Originally Issued On: 9/8/2025

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: Multiple cabinets in the facilities kitchens are in poor repair.
Comply By: 8/28/2026 Originally Issued On: 9/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: Facility does not have a way to measure internal temperature in high temperature dish machines.
Comply By: 10/10/2025 Originally Issued On: 9/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Sanitizer test kits are expired.
Comply By: 9/26/2025 Originally Issued On: 9/8/2025

New Order: 4-500 Equipment Maintenance and Operation
4-502.11B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.
COMMENT: Two dial thermometers are not calibrated. Person in charge discarded thermometers.
Comply By: Complied On Site Originally Issued On: 9/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: Can opener blade had food debris on it.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: Internal component of mixer is visibly soiled.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

! **New Order: 5-200B Plumbing: cross connections**
5-203.14A *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.
COMMENT: Ice machine drain tube is stored in the floor drain below the flood level.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.16 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.
COMMENT: Soiled mop head is stored in the mop bucket.
Comply By: 9/8/2025 Originally Issued On: 9/8/2025

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 F1033251168 from 9/8/2025

Isaiah Armendariz

Establishment Representative

Isaiah Armendariz,
Public Health Sanitarian 2
507-344-2743
isaiah.armendariz@state.mn.us