Electronically Delivered

July 25, 2025

Licensee
Abilit Holdings (Meadow Lakes)
22 45th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL21129016

Dear Licensee:

On June 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 10, 2025 and the follow-up survey completed on March 18, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

April 15, 2025

Licensee
Abilit Holdings (Meadow Lakes)
22 45th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL21129016

Dear Licensee:

On March 18, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 10, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 10, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 10, 2025, found not corrected at the time of the March 18, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 18, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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

§144G.20.

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.

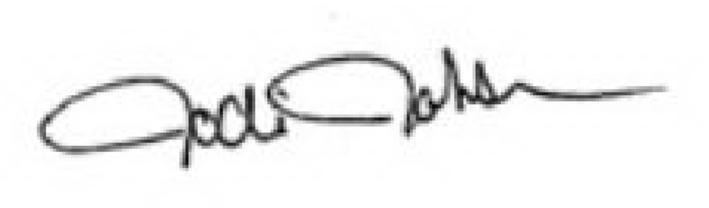
To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21129	A. BUILDING: _____ B. WING _____	R 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#21192016-1 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 10, 2025. At the time of the survey, there were 68 residents; 65 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued: 0780.	{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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis 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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{0 660}	Continued From page 2	{0 660}	Not reviewed during this survey	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 780}		

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{0 780}	Continued From page 3 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on January 9, 2025, from 11:50 a.m. through 1:14 p.m., with director of maintenance (DM)-K, the surveyor observed the following: SMOKE ALARMS Resident rooms had single-station smoke alarms installed inside the sleeping rooms and outside in the immediate vicinity of the sleeping rooms. The smoke alarms were battery operated and capable of being interconnected with wireless technology. On the ceiling next to each alarm was a blank round cover. When asked about the covers, DM-K stated that is where the old alarms had been located and the covers were installed to conceal the wire harness from the old alarms. DM-K stated the alarms were removed because they were more than five years old and confirmed that the old alarms were hard wired (connected to the buildings electrical wires). State Fire Code in Minnesota Rules, chapter 7511 requires that replacement smoke alarm power supply be the same as the smoke alarms being replaced. During the tour DM-K tested the smoke alarms. Resident rooms 101, 110, 113, 236, 234, 223, 217 and 205 had smoke alarms that were not interconnected so that activation of one alarm activates all alarms within the resident room. All resident units required to have multiple smoke alarms are required to have interconnected	{0 780}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

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{0 780}	Continued From page 4 alarms so activation of one alarm activates all alarms within the resident unit. On March 18, 2025, at 10:15 a.m. the surveyor initiated a follow up from the previous survey. DM-K and the surveyor entered resident room 101 and DM-K tested the smoke alarms. The smoke alarms were interconnected and operated properly. DM-K stated that five resident rooms were completed the same as room 101 and they were continuing to replace alarms in the remaining rooms as time allows. LOCKED EXIT During facility tour on January 9, 2025, from 11:50 a.m. through 1:14 p.m., with director of maintenance (DM)-K the surveyor observed an exterior door in the memory care wing that led to a fenced patio area. DM-K and the surveyor exited the building through this door and the surveyor observed two gates in the fence that were locked. When asked about the gate locks, DM-K stated that the gate locks were not connected to the fire alarm system and the only way to unlock them was with the code. DM-K and the surveyor re-entered the building and the surveyor observed an illuminated exit sign above the exterior door and the door was shown as an emergency exit on the posted evacuation maps. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. During interview on March 18, 2025, at 10:45 a.m. with DM-K and licensed assisted living director (LALD)-A, LALD-A stated that they had purchased all the smoke alarms that were available from their supplier and had them stored on-site. The remaining smoke alarms were	{0 780}		

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{0 780}	Continued From page 5 ordered. LALD-A and DM-K stated the locked gates were unchanged from the previous survey. LALD-A provided signed contracts from a company that was hired to install new gate locks. Emails from the company to the facility dated March 18, 2025, at 9:33 a.m. indicated that the company had all the material on hand and would complete the installation once permits had been obtained. No further information was provided.	{0 780}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01060}	Continued From page 6 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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	{01620}	Not reviewed during this survey	

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{01620}	Continued From page 7 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. (e) 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:	{01620}	Not reviewed during this survey	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}	Not reviewed during this survey	
{01890} SS=E	144G.71 Subd. 20 Prescription drugs	{01890}		

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{01890}	Continued From page 8 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:	{01890}	Not reviewed during this survey	
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	{01940}		

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{01940}	Continued From page 9 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:	{01940}	Not reviewed during this survey	

Electronically Delivered

February 19, 2025

Licensee
AbiliT Holdings (Meadow Lakes) LLC
22 45th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL21129016

Dear Licensee:

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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:
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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.

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

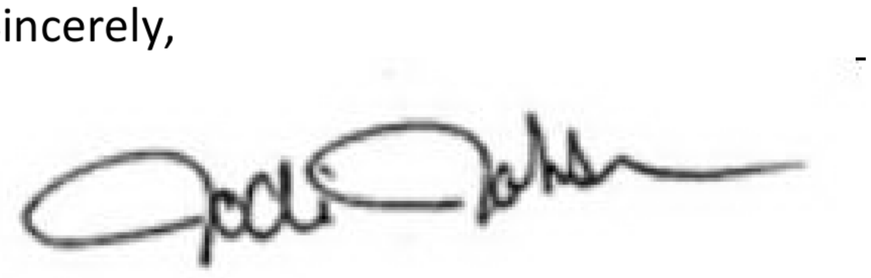
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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
	21129	A. BUILDING: _____ B. WING _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(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: SL21129016-0 On January 6, 2025, through January 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 65 residents; 59 receiving services under the Assisted Living Facility with Dementia Care license. 1750-An immediate order was issued on January 8, 2025, at a level 3/Widespread (I) The licensee took action on January 8, 2025; however, the scope and level remain at I. 1290: An immediate order was issued on January 9, 2025, at a level 3/Widespread (I) The licensee took action on January 9, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 510	Continued From page 1	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of one unlicensed personnel (ULP-C) during blood sugar testing and 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 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: On January 6, 2025, at 4:06 p.m., the surveyor	0 510		

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0 510	Continued From page 2 observed unlicensed personnel (ULP)-C preparing R1's blood sugar testing equipment and supplies for administering R1's insulin. ULP-C unlocked and opened the medication cabinet door. ULP-C donned clean gloves and gathered supplies. ULP-C wiped the third finger on R1's left hand, poked the finger with the lancet and drew a drop of blood. ULP-C assisted with placing the drop of blood on the blood sugar test strip and waited for the reading to appear. ULP-C then prepared R1's insulin pen by wiping the pen tip with alcohol wipe and placed the pen needle in place. ULP-C primed the pen with two units of insulin as required, assisted with insulin injection to R1's abdomen. ULP-C then gathered all the blood sugar equipment, test strip, and glucometer with the same gloves, went to a lower cabinet, disposed of the used blood test strip into a sharp's container, returned the glucometer and insulin pen to the locked medication cabinet and finally documented R1's blood sugar and insulin administration on the electronic tablet. ULP-C used the same gloves throughout the entire process and failed to remove her gloves, sanitize her hands, and don clean gloves before handling R1's insulin pen, touching multiple surfaces including the countertop, cabinet handles and her tablet. On January 7, 2025, at 1:45 p.m. clinical nurse supervisor (CNS)-B stated she expected all staff to always use proper hand hygiene and especially when working with blood borne pathogens such as blood sugar testing equipment. She expected the ULP to remove their potentially soiled gloves immediately after performing the blood sugar check and disposing of the soiled blood testing strip, sanitize hands and don clean gloves prior to moving on to next steps or touching other surfaces.	0 510		

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0 510	Continued From page 3 The licensee's Hand washing policy dated August 1, 2021, indicated proper hand washing techniques should be used to protect the spread of infection hand washing shall be completed after changing diapers or cleaning up after someone who has used the toilet. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis 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.	0 660		

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0 660	Continued From page 4 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB PREVENTION PROGRAM On January 6, 2025, the surveyor requested the licensee's TB Risk Assessment. On January 8, 2025, at 4:30 p.m., the surveyor received the licensee's TB Risk Assessment Worksheet for Health Care settings and was noted to be undated and incomplete (lacked an indication of the designated person to manage the TB Plan and lacked the date last completed.) The TB Risk Assessment indicated the licensee was a low-risk health care setting. On January 8, 2025, at 4:50 p.m., licensed assisted living director (LALD)-A stated she thought the TB Risk Assessment had been completed sometime in July of 2024. She stated	0 660		

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0 660	Continued From page 5 she thought the nurses were managing the TB Risk Assessment. The licensee's Tuberculosis Screening Policy dated September 25, 2022, indicated the Community will establish and maintain a comprehensive tuberculosis (TB) control program according to the most current TB infection control guidelines issues by the CDC. The program includes a TB infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The Community will maintain a current community TB risk assessment. The assessment will be updated annually, using data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 6 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on January 9, 2025, from 11:50 a.m. through 1:14 p.m., with director of maintenance (DM)-K, the surveyor observed the following: SMOKE ALARMS Resident rooms had single-station smoke alarms installed inside the sleeping rooms and outside in the immediate vicinity of the sleeping rooms. The smoke alarms were battery operated and capable	0 780		

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0 780	Continued From page 7 of being interconnected with wireless technology. On the ceiling next to each alarm was a blank round cover. When asked about the covers, DM-K stated that is where the old alarms had been located and the covers were installed to conceal the wire harness from the old alarms. DM-K stated the alarms were removed because they were more than five years old and confirmed that the old alarms were hard wired (connected to the buildings electrical wires). State Fire Code in Minnesota Rules, chapter 7511 requires that replacement smoke alarm power supply be the same as the smoke alarms being replaced. During the tour DM-K tested the smoke alarms. Resident rooms 101, 110, 113, 236, 234, 223, 217 and 205 had smoke alarms that were not interconnected so that activation of one alarm activates all alarms within the resident room. All resident units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the resident unit. FIRE RESISTANT RATED DOORS Fire-resistant rated doors must automatically close and latch to prevent the spread of smoke and fire to adjoining building areas. During the tour the surveyor observed the following fire-resistant rated doors were not maintained to automatically close and latch. One hour rated door into first floor laundry room by resident room 106 was held open with a toe-kick device. When the device was released, the door did not fully close and latch. One hour rated door into garage by resident room 108 did not latch. One hour rated door into first floor activity room was held open with a toe-kick device. The door was equipped with an automatic door closer, but	0 780		

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0 780	Continued From page 8 the closer had been disabled so it did not self-close. One hour door into first floor laundry room by memory care wing was held open with a wedge. One hour rated door into second floor laundry room by resident room 228 was held open with a toe-kick device. When the device was released, the door did not fully close and latch. One hour rated door into activity office was held open with a brick. LOCKED EXIT During the tour the surveyor observed an exterior door in the memory care wing that led to a fenced patio area. DM-K and the surveyor exited the building through this door and the surveyor observed two gates in the fence that were locked. When asked about the gate locks, DM-K stated that the gate locks were not connected to the fire alarm system and the only way to unlock them was with the code. DM-K and the surveyor re-entered the building and the surveyor observed an illuminated exit sign above the exterior door and the door was shown as an emergency exit on the posted evacuation maps. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. During interview on January 9, 2025, at 1:14 p.m. with DM-K and licensed assisted living director (LALD)-A, the surveyor discussed the above findings. DM-K stated they would remove the toe-kick devices and educate staff to not to prop doors open. DM-K and LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 10 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living with dementia care (ALFDC) services from the licensee on June 19, 2023. R1's Service Plan dated October 15, 2024, indicated she received medication administration and blood sugar monitoring. On January 6, 2025, at 4:06 p.m., the surveyor observed unlicensed personnel (ULP)-C complete R1's blood sugar check, and set up and administer R1's medications. R1's progress notes included:	01060		

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01060	Continued From page 11 -September 1, 2024, resident had gone out with family. Son called and notified staff that resident fell while out with family and has been admitted to the hospital and will be there until at least Tuesday. Staff notified nurse that resident is at the hospital. -September 16, 2024, resident returned from the hospital today. She has some changes to her medications. Resident will be needing some additional services with mobility, transferring, dressing of the lower body, and showers. Resident is happy to be back home and went down for the evening meal. R1's hospital progress note dated September 13, 2024, indicated she remained hospitalized following a surgical repair of a left humeral (forearm bone) fracture sustained following a fall on August 31, 2024. R1's record lacked a written notice for the hospitalization that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's records lacked notification to the	01060		

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01060	Continued From page 12 Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days for the hospitalization dated September 1, 2024, through September 16, 2024. On January 8, 2025, at 3:10 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of the emergency relocation requirement nor the need to notify the ombudsman for a resident not returning to the facility within four days following an emergency relocation. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(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
01290	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living with dementia care license for one of 45 employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on January 9, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on July 16, 2020, to provide direct care services for the licensee's residents. On January 6, 2025, at 4:20 p.m., the surveyor observed ULP-D complete a blood sugar check and administer an insulin injection to R2. On January 9, 2025, at 12:55 p.m., licensed assisted living director (LALD)-A provided the surveyor with the NETStudy 2.0 roster for health facility identification number (HFID) 21129. ULP-D's background study was affiliated to HFID 21129, but indicated "Eligible-COVID-19 Study-Expired" with an expiration date of December 31, 2022, on the NET Study 2.0	01290		

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01290	Continued From page 14 website roster page. LALD-A stated she was not aware ULP-D's background study was COVID-19 Study expired and stated all employees were required to have a cleared background check before performing duties at the facility. LALD-A further stated ULP-D had worked independently without supervision. The licensee's Background Studies policy dated August 1, 2021, indicated [licensee name] will conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The Minnesota Department of Human Services website updated July 31, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid and modifications ended January 1, 2023. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an	01290		

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01290	Continued From page 15 emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on January 9, 2025; however, the scope and level remain at I.	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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.	01620		

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01620	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) complete a reassessment not to exceed 90 days for three of four residents (R1, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 began receiving services under the licensee's assisted living with dementia care (ALFDC) license on June 19, 2023. R1's Service Plan dated October 15, 2024, indicated she received the services of medication administration and blood sugar monitoring. On January 7, 2025, at 1:45 p.m., R1's last three comprehensive assessments were requested. Comprehensive assessments dated April 29, 2024, August 21, 2024, September 17, 2024, and October 2, 2024, were provided. The August 21, 2024, assessment was 114 days after the previous assessment date (24 days late), thus exceeding 90 calendar days. R3	01620		

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01620	Continued From page 17 R3 began receiving services under the licensee's ALFDC license on September 24, 2020. R3's Service Plan dated November 7, 2024, indicated she received the services of medication administration, compression stocking management, hospice services, and assistance with all cares. R3's last three assessments were requested. R3's comprehensive assessments dated April 4, 2024, June 28, 2024, and October 16, 2024, were provided. The October 16, 2024, assessment was 110 days after the previous assessment date (20 days late), thus exceeding 90 calendar days. R5 R5 began receiving services under the licensee's ALFDC license on January 31, 2024. R5's Service Plan dated September 6, 2024, indicated he received the services of medication management, behavior management, and safety checks. R5's last three assessments were requested. R5's comprehensive assessments dated February 5, 2024, March 12, 2024, September 6, 2024, and December 6, 2024, were provided. The September 6, 2024, assessment was 178 days after the previous assessment date (88 days late), thus exceeding 90 calendar days. On January 8, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-B reviewed the assessment dates for R1, R3, and R5, and stated R1 and R3's assessments were late likely related to a transition in the licensee's electronic medical record (EMR) system, and she was delayed in completing some of the resident's assessments.	01620		

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01620	Continued From page 18 She further stated she missed R5's 90-day assessment due in June 2024, altogether. The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-G) completed training	01750		

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01750	Continued From page 19 and competency evaluations for medication administration prior to administering medications. This resulted in an immediate correction order identified on January 8, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-G began providing cares services under the Assisted Living with Dementia Care (ALFDC) license on December 30, 2024. On January 7, 2025, at 8:10 a.m., ULP-G was following ULP-F (the designated trainer) for cares and medication administration. ULP-G was observed to set up (check medication administration record (MAR), check the medication labels, and dispense R4's ten morning oral medications into a medication cup, as ULP-F observed. ULP-F documented her initials on the medication card and on the MAR for the medication set up. ULP-G also set up R4's lidocaine pain patch and toenail fungal oil for administration. ULP-F administered R4's oral medications, applied the lidocaine pain patch to R4's lower back, and applied R4's toenail fungal oil to her left great toe. ULP-F stated ULP-G was training with her and could set up medications but was not allowed to document medication set up or administration.	01750		

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01750	Continued From page 20 ULP-G stated he had not yet had formal medication training or been "checked off" by a registered nurse. ULP-F stated, "This is how we do the medication training. The new staff observe and train with us and can start setting the medications up but cannot sign for them." R5 R5's diagnoses included dementia, glaucoma (increased eye pressure), and hypertension. R5's Service Plan dated September 6, 2024, indicated he received the service of medication administration. R5's signed medication orders dated August 2, 2024, included: -dorzolamide-Timolol (for glaucoma) 22.3-6.8 milligrams/milliliter (mg/ml), administer one drop to both eyes two times daily; -dorzolamide 2% ophthalmic (for glaucoma) solution, one drop in both eyes two times daily; -dorzolamide 2% ophthalmic solution, administer one drop into both eyes daily; -Timolol 0.5% ophthalmic solution, administer one drop in both eyes daily; and -Alphagan 0.1%, administer one drop into both eyes two times a day R5's MAR dated January 2025, included: -dorzolamide-Timolol solution 2-0.5% instill one drop in both eyes two times daily with the assigned times at 8:30 a.m. and 7:00 p.m. -Alphagan solution 0.1%, instill one drop in both eyes two times daily with the assigned times at 7:30 a.m. and 7:00 p.m. On January 7, 2025, at 9:05 a.m., ULP-G continued to shadow/train with ULP-F as the designated trainer. ULP-G was observed to set	01750		

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01750	Continued From page 21 up six oral medications and two glaucoma eye drop medications for R5. The eye drops had labels that read: -dorzolamide-Timolol 2%-0.5% with R5's name, and an unreadable open date. The label lacked R5's dose and route of administration. -dorzolamide 2% (22.3 mg/ml) with R5's name and an open date of January 6, 2025. The label lacked R5's dose and route of administration. ULP-G set the medications on the table as he waited for R5. When R5 came to the living room area, ULP-F administered his oral medications. ULP-G then donned clean gloves and administered one glaucoma eye drop to each eye as ordered. ULP-F then immediately administered the second glaucoma eye drop medication to both eyes. ULP-G failed to wait the designated one to two minutes between administering two types of eye drops. ULP-F and ULP-G both stated they were not aware the eye drops were to be spaced several minutes apart. ULP-F and ULP-G did not indicate one of the scheduled eye drops was to be given at 7:30 a.m. On January 7, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee's practice is for new ULP to shadow a designated ULP and observe medication administration. After some observations of the designated ULP, the new ULP was to be observed by the registered nurse and "signed off as competent", until they were able to take a formal medication administration class. CNS-B stated ULP-G should not have been touching medications or administering them, but only observing the designated ULP. CNS-B stated she had not yet met with ULP-G and did not know who he was. On January 8, 2025, at 10:00 a.m., the surveyor	01750		

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01750	Continued From page 22 and CNS-B reviewed R5's signed medication orders, R5's MAR, and the eye drops stored in R5's medication cupboard to determine what eye drops were supposed to have been given by the ULP. CNS-B confirmed the dorzolamide-timolol 2%-0.5% and dorzolamide 2% to be found in R5's medication cabinet. CNS-B stated R5's Alphagan eye drops were not in the medication cabinet. CNS-B placed a call to the pharmacy to clarify what the pharmacy had for active orders. The pharmacy personnel indicated the following active orders: -Alphagan 0.1% eye drops, give one drop twice daily, and was last refilled November 14, 2024; and -dorzolamide-Timolol 22.3-6.8 mg/ml, one drop both eyes twice daily The pharmacy personnel also indicated the orders for dorzolamide 2% solution given daily, and the Timolol 0.5% solution given daily had been discontinued in July 2024. CNS-B determined R5's Alphagan was not reordered and the ULP were using the discontinued dorzolamide 2% in its place. ULP-G's employee file lacked evidence he had been trained by a registered nurse nor had been deemed competent to administer medications prior to completing medication administration to residents. Furthermore, the licensee failed to ensure the proper eye drops were administered and failed to administer the eye drops per the time indicated on the MAR, or in a timeline that allowed one to two minutes between each set of eye drops. The licensee's Medications and Treatments-Administration and Delegation policy dated August 1, 2021, indicated when	01750		

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01750	Continued From page 23 administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. Additionally, a RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. The licensee's Eye Drop and Eye Ointment procedure dated August 1, 2021, indicated only properly trained staff of [licensee name] may provide medication assistance or administration. ULP must be trained, and competency tested,	01750		

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01750	Continued From page 24 with documentation on file. Eye drop and eye ointment medications must be administered according to the prescriber's orders. If more than one kind of eye drop is being used, wait at least 1-2 minutes before using each type. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on January 8, 2025; however, the scope and level remain at I. In addition, the licensee failed to specify in writing specific instructions for one of one resident (R3) and documented the instructions in the resident record as required. The findings include: R3's diagnoses included dementia, history of pneumonia, heart disease, and hypertension. R3's Service Plan dated November 7, 2024, indicated R3 received services to include medication management/administration. On January 7, 2025, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R3's medications. R3's Medication Plan incorporated into R3's comprehensive assessment dated October 16, 2024, indicated the licensee was managing R3's medication services. R3's medication administration record (MAR) dated January 2025, indicated she received	01750		

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01750	Continued From page 25 medications to include two seizure medications, one for dementia, one for depression, one for agitation, one for anxiety/shortness of breath, one for heart rate, one for acid reflux, one for excessive secretions, two for pain, one antifungal, and one eye drop for dry eyes, two scheduled medications for constipation and two as needed (PRN) medications for constipation. R3's medication orders dated August 5, 2024, indicated: - Senna 8.6 milligrams (mg), one tablet daily and one tablet orally daily as needed for constipation; and - MiraLAX 17 grams (gm), mix 17 gm with 240 milliliters (ml) fluid daily as needed for constipation R3's record included two PRN medications for constipation. The licensee failed to provide written instruction to direct the ULP on which PRN to use first. On January 9, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated she was not aware the registered nurse (RN) needed to specify the instructions for the ULP to administer multiple PRN medications to address the same symptom. The licensee's Medication and Treatment Administration and Delegation Plan policy dated August 1, 2021, indicated When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has: -instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures	01750		

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01750	Continued From page 26 -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the proper medication was given and failed to follow the proper procedure with eye drop administration for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(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
01760	Continued From page 27 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: R5 began receiving services under the licensee's assisted living with dementia care (ALFDC) license on January 31, 2024. R5's diagnoses included dementia, glaucoma (increased eye pressure), and hypertension. R5's Service Plan dated September 6, 2024, indicated he received the service of medication administration. R5's MAR dated January 2025, indicated he received one medication for anxiety, one for high blood pressure, one to thin blood, one for cholesterol, one supplement, one nebulizer for shortness of breath, two for rheumatoid arthritis, one for heart rate control, and two eye drops for glaucoma. Furthermore, the MAR indicated: -dorzolamide-timolol solution 2-0.5% instill one drop in both eyes two times daily with the assigned times at 8:30 a.m. and 7:00 p.m. -Alphagan solution 0.1%, instill one drop in both eyes two times daily with the assigned times at 7:30 a.m. and 7:00 p.m. R5's signed medication orders dated August 2, 2024, included: -dorzolamide-timolol (for glaucoma) 22.3-6.8 milligrams/milliliter (mg/ml), administer one drop to both eyes two times daily;	01760		

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ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

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01760	Continued From page 28 -dorzolamide 2% ophthalmic (for glaucoma) solution, one drop in both eyes two times daily; -dorzolamide 2% ophthalmic solution, administer one drop into both eyes daily; -Timolol 0.5% ophthalmic solution, administer one drop in both eyes daily; and -Alphagan 0.1%, administer one drop into both eyes two times a day On January 7, 2025, at 9:05 a.m. the surveyor observed ULP-G shadow/train with ULP-F as the designated trainer. ULP-G was observed to set up six oral medications and two glaucoma eye drop medications for R5. The eye drops had labels that read: -dorzolamide-Timolol 2%-0.5% with R5's name, and an unreadable open date. The label lacked R5's dose and route of administration. -dorzolamide 2% (22.3 mg/ml) with R5's name and an open date of January 6, 2025. The label lacked R5's dose and route of administration. ULP-G set the medications on the table as he waited for R5. When R5 came to the living room area, ULP-F administered his oral medications. ULP-G then donned clean gloves and administered one glaucoma eye drop to each eye as ordered. ULP-F then immediately administered the second glaucoma eye drop medication to both eyes. ULP-G failed to wait the designated one to two minutes between administering two types of eye drops. ULP-F and ULP-G both stated they were not aware the eye drops were to be spaced several minutes apart. ULP-F and ULP-G did not indicate one of the scheduled eye drops was to be given at 7:30 a.m. On January 8, 2025, at 10:00 a.m., the surveyor and CNS-B reviewed R5's signed medication orders, R5's MAR, and the eye drops stored in	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

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01760	Continued From page 29 R5's medication cupboard to determine what eye drops were supposed to have been given by the ULP. CNS-B confirmed the dorzolamide-Timolol 2%-0.5% and dorzolamide 2% to be found in R5's medication cabinet. CNS-B stated R5's Alphagan eye drops were not in the medication cabinet. CNS-B placed a call to the pharmacy to clarify what the pharmacy had as active orders. The pharmacy personnel indicated the following active orders: -Alphagan 0.1% eye drops, give one drop twice daily, and was last refilled November 14, 2024; and -dorzolamide-Timolol 22.3-6.8 mg/ml, one drop both eyes twice daily The pharmacy personnel also indicated the orders for dorzolamide 2% solution given daily, and the Timolol 0.5% solution given daily had been discontinued in July 2024. CNS-B determined R5's Alphagan was not reordered and the ULP were using the discontinued dorzolamide 2% in it's place. The licensee failed to ensure the proper eye drops were administered and failed to administer the eye drops per the time indicated on the MAR, or in a timeline that allowed one to two minutes between each set of eye drops. The licensee's Medications and Treatments-Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform	01760		

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01760	Continued From page 30 treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. Additionally, a registered nurse (RN) must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. The licensee's Eye Drop and Eye Ointment procedure dated August 1, 2021, indicated only properly trained staff of [licensee name] may provide medication assistance or administration. ULP must be trained, and competency tested, with documentation on file. Eye drop and eye ointment medications must be administered according to the prescriber's orders. If more than one kind of eye drop is being used, wait at least 1-2 minutes before using each type.	01760		

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ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

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01760	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date or included a proper label for three of three residents (R1, R2, R7) with insulin 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 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 included: R1 R1's Service Plan dated October 15, 2024,	01890		

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01890	Continued From page 32 indicated she received services to include medication administration. R1's signed prescriber's orders dated September 13, 2024, indicated Novolog insulin 100 units/milliliter (u/ml), give 7 units three times daily in combination with the following sliding scale (additional insulin dosing based on the blood sugar level at that time): -for blood sugars less than 180-no additional dosing -for blood sugar 180-219: give additional 2 units insulin -for blood sugar 220-259: give additional 3 units insulin -for blood sugar 260-299: give additional 4 units insulin -for blood sugar 300-339: give additional 5 units insulin -for blood sugar 340-379: give additional 6 units insulin -for blood sugar 380-399: give additional 7 units insulin -for blood sugar over 400: call provider On January 6, 2025, at 4:06 p.m., the surveyor observed unlicensed personnel (ULP)-C to set up and administer R1's insulin. The surveyor observed R1's Novolog insulin pen stored in R1's locked medication cabinet (stored at room temperature) and lacked an open date. ULP-C stated she did not know when the insulin pen was opened. R2 R2's Service Plan dated June 5, 2024, indicated she received services to include medication administration. R2's signed prescriber's orders dated March 17,	01890		

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01890	Continued From page 33 2024, indicated Novolog 100 u/ml, inject 9 units under the skin three times a day with meals. Take 9 units with each meal. If you skip a meal, do not give yourself insulin. If sugar is less than 90, hold. Plus, sliding scale insulin on top of scheduled dose for each meal based on blood sugar level: -insulin correction dose less than 180: No additional insulin, -180-219: 2 units, -220-259: 3 units, -260-299: 4 units, -300-339: 5 units, -340-379: 6 units, -380-399: 7 units, -400-499: 8 units, -greater than or equal to 500: Call your provider. On January 6, 2025, at 4:20 p.m., the surveyor observed ULP-D set up and administer R2's fiosp (Novolog) insulin. The insulin was stored in R2's locked medication cabinet at room temperature. The surveyor noted no open date on the insulin pen. ULP-D stated she was not sure when the insulin pen was opened. R7 R7's Service Plan dated October 22, 2024, indicated he received services to include medication administration. R7's signed prescriber's orders dated September 10, 2024, indicated: -Humalog 100 u/ml, give 15 units at breakfast, lunch, and supper -Lantus 100 u/ml, give 20 units in the morning and 14 units in the evening On January 7, 2025, at 11:00 a.m., the surveyor observed ULP-H set up and administer R7's Humalog insulin. The surveyor noted the	01890		

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01890	Continued From page 34 Humalog insulin pen was stored in R7's locked medication cabinet at room temperature. The insulin pen lacked an open date. Additionally, the surveyor noted R7's Lantus insulin pen as stored in the locked medication cabinet at room temperature, was without an indicated open date. ULP-H stated she was not sure when either insulin pen had been opened, and further stated the staff should be indicating when the insulin pens are opened with an open date. On January 7, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated all insulin pens should be dated once opened/stored at room temperature. Novolog insulin manufacturer's instructions dated April 2015, indicated once opened store insulin pen at room temperature, and discard after 28 days of use even if insulin is still present in the pen. Humulin insulin manufacturer's instructions dated June 2022, indicated discard used insulin pen 14 days after opening. Lantus insulin manufacturer's instructions dated 2022, indicated do not refrigerate after opening and discard after 28 days once opened/used even if insulin is still present in the pen. The licensee's Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 35 days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01940		

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01940	Continued From page 36 licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R7) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on January 6, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including blood sugar checks. R1 R1's diagnoses included type two diabetes, depression, and anxiety. R1's Service Plan dated October 15, 2024, indicated R1 received services including medication management and blood sugar monitoring. On January 6, 2025, at 4:06 p.m., the surveyor observed unlicensed personnel (ULP)-C checking R1's blood sugar via finger poke and glucometer (blood sugar testing unit). R1's blood sugar reading was 166. R1's signed prescriber's orders dated September 13, 2024, indicated blood glucose (blood sugar)	01940		

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01940	Continued From page 37 monitoring to be done four times daily before meals and at bedtime with a blood sugar goal of 100-140. R1's comprehensive assessment dated September 13, 2024, indicated blood glucose (blood sugar) checks were done as prescribed (see medication administration record (MAR). R1's Medication/Treatment Assessment dated October 2, 2024, indicated blood glucose checks were done as prescribed (see MAR). R1's MAR dated January 2025, indicated Easy Touch Health Pro glucometer strip-use as directed to test blood sugar four times daily. R1's treatment record lacked the required content to include: - documentation of specific resident instructions relating to the treatments or therapy administration to include blood sugar parameters; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services R7 R7's diagnoses included traumatic brain injury, compression fracture of lumbar vertebrae, type one diabetes with insulin dependence, and bipolar disorder. R7's Service Plan dated October 22, 2024, indicated R7 received services including insulin administration and blood sugar monitoring. On January 7, 2025, at 11:00 a.m. ULP-H observed R7 as he checked his blood sugar via	01940		

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01940	Continued From page 38 his Dexcom unit (a blood sugar monitoring device which allows continuous blood sugar readings between a patient and a phone application). The blood sugar reading was 114. ULP-H then prepared R7's insulin and administered to R7's lower abdomen. ULP-H stated the ULP document the blood sugar in the same area of the MAR as the Humulin insulin dose. ULP-H stated she was not aware of the blood sugar parameters for R7, and stated "we usually let the nurse know if above 300 for the residents with blood sugar checks.) R7's signed prescriber's orders dated September 10, 2024, indicated check blood sugar premeal and at bedtime. Allow R7 to continue using Dexcom sensor. A prescription for a glucometer was also written today. Double check low blood sugars (less than 70) with glucometer. Contact endocrinology nurse if R7 is experiencing blood sugars out of target range with lows less than 70 and above 350. R7's comprehensive assessment dated October 22, 2024, included R7's Treatment/Diabetes Plan and read R7 had a condition requiring regular glucose testing and monitoring, and used insulin to manage diabetes symptoms. R7's Medication/Treatment assessment dated October 22, 2024, indicated R7 could manage his own medications but needed assistance with monitoring blood sugar checks and administering insulin. R7's Medication Administration Record (MAR) dated January 2025, included Dexcom G7 receiver and sensor without a schedule of use, and Easy touch Health pro glucose strips and monitor without a schedule of use. The MAR included blood sugar readings with each Humulin	01940		

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01940	Continued From page 39 dosing time (7:15 a.m., 11:15 a.m., 4:15 p.m.). No further instructions were included to indicate blood sugar parameters, nor to recheck blood sugar readings with a finger poke and glucometer use when the Dexcom unit indicated a low blood sugar (below 70), as ordered. R7's treatment record lacked the required content to include: - documentation of specific resident instructions relating to the treatments or therapy administration to include blood sugar parameters, recheck by fingerstick and glucometer when the Dexcom unit indicated a low blood sugar; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services On January 9, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the need to clarify blood sugar parameters and would add to the treatment records. The licensee's Medication and Treatment Administration and Delegation Plan policy dated August 1, 2021, indicated When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has: -instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the unlicensed personnel	01940		

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ABILIT HOLDINGS (MEADOW LAKES)	22 45TH AVENUE NW ROCHESTER, MN 55901

(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
01940	Continued From page 40 about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *01/09/25*
Time: 10:46:43
Report: 1038251004

Food and Beverage Establishment Inspection Report

Location:
Abilit Holdings (Meadow Lakes)
22 45th Avenue Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0037688
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072525069
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PENDING CARD IN THE MAIL
Comply By: 01/09/25

Surface and Equipment Sanitizers

Hot Water: = at 160.2 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Buns
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Butter
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: Vegitable Meddly
Violation Issued: No

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Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Buns
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Green Beans
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

tmuenzhuber@meadowlakesmn.com

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038251004 of 01/09/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Signed:_____
Establishment Representative

Signed:_____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us