Electronically Delivered

January 15, 2026

Licensee
Brooke Manor Inc
4878 Highway 31
Brookston, MN 55711

RE: Project Number(s) SL30235016

Dear Licensee:

On December 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 10, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Electronically Delivered

October 21, 2025

Licensee
Brooke Manor Inc
4878 Highway 31
Brookston, MN 55711

RE: Project Number(s) SL30235016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 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 . . ."

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

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	30235	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30235016 On July 7, 2025, through July 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were eight residents receiving services under the Assisted Living Facility license. An immediate correction order was issued on July 8, 2025, for tag identification 2310, issued at a scope and level of isolated, level two (D). The licensee took mitigating action to correction the correction order, however, non-compliance remains at a scope and level D.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective October 1, 2024. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally	0 420		

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0 420	Continued From page 2 responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/agent on June 24, 2024. As a result of this survey, the following orders were issued under 0420, 0470, 0495, 0630, 0640, 0650, 0680, 0775, 0780, 0790, 0800, 0810, 0950, 1060, 1420, 1490, 1500, 1530, 1565, 1620, 1640, 1750, 1790, 1880, 1890, 1950, 2310, 2430 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required	0 470		

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0 470	Continued From page 3 by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure an evaluation was conducted at least twice a year by the clinical nurse supervisor (CNS), of the appropriateness of staffing levels in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470		

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0 470	Continued From page 4 The licensee held an assisted living facility license. The facility was licensed for ten residents and had a current census of eight residents. On July 7, 2025, at 10:57 a.m., during the entrance conference with licensed assisted living director/owner (LALD/O)-A and CNS-C, CNS-C stated we (licensee) "can allow (admit residents who require) one staff (unlicensed personnel/ ULP) to transfer." CNS-C stated the staffing plan was: - one ULP worked from 6:00 a.m. until 2:00 p.m., "and sometimes we have two (ULP)" "we (licensee) will have someone else (ULP) come a little later, normally one, we can have two (ULP) for appointments, and showers etc." - one ULP worked from 2:00 p.m. until 10:00 p.m., "for sure." CNS-C stated we (licensee) have students, they (students/ULP) work during the summer) (may have more ULPs scheduled) - one ULP worked from 10:00 p.m. until 6:00 a.m. The schedule for July 7, 2025, through July 11, 2025, noted: - Monday: one ULP 6:00 a.m. until 2:00 p.m.; one ULP 2:00 p.m. until 10:00 p.m.; one ULP 10:00 p.m. until 6:00 a.m. - Tuesday: one ULP 6:00 a.m. until 2:00 p.m.; one ULP 10:00 a.m. until 6:00 p.m.: one ULP 6:00 p.m. until 10:00 p.m.; one ULP 10:00 p.m. until 6:00 a.m. - Wednesday: one ULP 6:00 a.m. until 2:00 p.m.; one ULP 7:00 a.m. until 3:00 p.m.; one ULP 2:00 p.m. until 10:00 p.m.; one ULP 6:00 p.m. until 10:00 p.m.; one ULP 10:00 p.m. until 6:00 a.m. - Thursday: one ULP 6:00 a.m. until 2:00 p.m., one ULP 2:00 p.m. until 10:00 p.m., one ULP 10:00 p.m. until 6:00 a.m. - Friday: one ULP 6:00 a.m. until 2:00 p.m.; one ULP 9:00 a.m. until 2:00 p.m.; one ULP from 2:00	0 470		

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0 470	Continued From page 5 p.m. until 10:00 p.m.; one ULP 10:00 p.m. until 6:00 a.m. The licensee's Direct-Care Staffing Plan, un-authenticated, and undated noted: One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be: - awake - located in the same building - capable of communicating with residents - capable of summoning appropriate assistance - capable of following directions. A registered nurse (RN) will be available to staff working at all times. Availability may be in person, via phone, or via other electronic communication method. - number of staff scheduled per shift: 1-2 - number of independent residents: 3 - number of residents requiring one-person assist: 5 - number of residents requiring two-person assist: 0 Daily shifts to include: - 6:00 a.m., to 2:00 p.m. - 7:00 a.m., to 3:00 p.m. - 2:00 p.m., to 8:00 p.m. - 2:00 p.m. to 10:00 p.m. - 10:00 p.m. to 6:00 a.m. Daily staffing is one staff person awake per shift with a second person to assist with appointments, community outings, etc. - (name of facility/licensee) does not have a secured dementia care unit. On July 7, 2025, at 12:52 p.m., LALD/O-A stated the licensee got form from "Leading Age" (organization dedicated to serving the aging	0 470		

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0 470	Continued From page 6 population). LALD/O-A stated she (LALD/O-A) just reviewed the form. The surveyor and LALD/O-A reviewed the form used. LALD/O-A stated there was no evidence of when the form was last reviewed, and that the form was reviewed at least twice a year by the CNS. LALD/O-A stated she would look elsewhere for "the form". On July 8, 2025, at 10:45 a.m., LALD/O-A stated she could not find another form and that the licensee had no evidence the staffing needs were evaluated at least twice yearly. LALD/O-A stated she (LALD/O-A) did "do it" (reviewed staffing), but there was no documentation. LALD/O-A stated it must not have been that long ago the plan was reviewed as the facility had had seven residents, not eight "not that long ago." The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy reviewed November 15, 2023, noted the staffing plan will provide qualified direct-care staff sufficient to meet the resident's needs 24-hours a day, seven-days a week and would be adequate to address: - each resident's needs as identified in the service plan and assisted living contract - each resident's acuity level as determined by the most recent assessment or individualized review - ability to meet the resident's scheduled and reasonable unforeseeable unscheduled needs given the physical layout of the facility premises requirements and the needs of the residents - the staffing plan would indicate if the assisted living had a secured dementia care unit - staff competency and training The staffing plan would be evaluated for appropriately of staffing levels in the facility and reviewed as needed at a minimum of two times	0 470		

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0 470	Continued From page 7 per year. The CNS would develop a 24-hour daily staffing schedule. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 495		

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0 495	Continued From page 8 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 7, 2025, at 10:14 a.m., during the entrance conference with licensed assisted living director/owner (LALD/O)-A stated the clinical nurse supervisor (CNS)-C was at "work and "had to sit through a required meeting." LALD/O-A stated CNS-C was the "head nurse at a clinic in [name of location/city]. LALD/O-A stated CNS-C was on site in the evenings a couple days a week and one day on the weekend usually. LALD/O-A stated CNS-C would be at the site after her mandatory meeting. LALD/O-A stated there were no additional nurses at the facility and CNS-C could sometimes not answer the phone but CNS-C would answer a text message. LALD/O-A added the texts were sent just to alert CNS-C to a message in the on-line system used. LALD/O-A stated the staff could also contact the facilities rounding medical provider as she (medical provider) had stated the facility could contact her if and as needed. LALD/O-A stated the call back time (for CNS-C) was "just a few minutes." LALD/O-A stated CNS-C worked from home "a lot and only went into the clinic on occasion." On July 7, 2025, at 10:18 a.m., during the entrance conference, LALD/O-A stated "we" (licensee/staff) could also contact Elder Care (service similar to Hospice) if and as needed for medical assist/calls. On July 7, 2025, at 10:30 a.m., CNS-C stated she was not supposed to have her phone on her during the time she worked at the clinic, "can't be	0 495		

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0 495	Continued From page 9 chit chatting at it." CNS-C added on Mondays she had a meeting. CNS-C stated she took call for the site (facility) 24/7. CNS-C added sometimes at night it takes her (CNS-C) a minute to wake up. CNS-C stated she took call when she (CNS-C) was on vacations and on holidays. On July 7, 2025, at 10:34 a.m., CNS-C stated she will call and check in on them (unlicensed personnel/ULP) and see how they (ULPs) are doing. CNS-C stated she does take vacations via air fights. CNS-C stated she was not available when in flight. CNS-C stated she was not aware that was not "ok" (to be unavailable) as she called prior to the flight departure to let ULPs know she would be unavailable. On July 9. 2025, at 7:17 p.m., ULP-F stated CNS-C did not answer the phone when ULP-F called CNS-C in regard to a medical concern for R1. ULP-F stated she could not reach LALD/O-A either. ULP-F stated LALD/O-A called ULP-F back and LALD/O-A came to the site to assist ULP-F to get R1 back into bed. On July 10, 2025, at 10:56 a.m., LALD/O-A stated in the past the licensee employed another RN but that RN was no longer employed by the facility. LALD/O-A stated she had been trying to hire another RN to have as a backup RN. LALD/O-A also stated the facility's rounding provider had stated the licensee could contact her (rounding provider) if and as needed. LALD/O-A pointed out to the surveyor the rounding provider's phone number for ULPs to use. R7's Resident Agreement dated May 22, 2025, noted: - RN reachable by staff 24/7.	0 495		

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0 495	Continued From page 10 The licensee's Clinical Nurse Supervisor Job Description authenticated November 30, 2021, noted: - hours five plus hours /week and on-call 24/7. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy reviewed November 15, 2023, noted a RN would be available to staff working at all times. Availability may be in person, via phone, or via other electronic communication method. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 11 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R7, R8). 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: R7 R7's diagnosis included alcohol use disorder, anxiety, and suicidal ideation. R7's record did not include a signed service plan. On July 8, 2025, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R7's morning medication using correct technique. R7's assessment dated May 22, 2025, included: - resident is at risk to be abused (physically, verbally, emotionally, financially, and/or sexually), specify measures to minimize risk: resident at	0 630		

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0 630	Continued From page 12 risk of abuse related to confusion and not being able to accurately describe an act of abuse directed toward him. - resident is at risk to abuse other vulnerable adults-specify measures to minimize risk: resident is at risk to verbally abuse towards staff regarding when and how to pass medication, and how the medications are stored. Becomes verbally aggressive when having anxiety regarding appointments, transportation. Is verbally aggressive towards staff when questioned regarding where he is going and how long he will be gone on this bike. Is at risk of running into/injuring other residents when walking too fast, with head down, due to alcohol use. R7's IAPP did not include specific interventions for the identified vulnerability as required. R8 R8's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), Alzheimer's disease, chronic fatigue, and developmental disability. R8's service plan dated February 23, 2022, indicated R8 received assist with support stockings (TEDs/compression hose), dressing, grooming, incontinence care and bathing assistance. On July 8, 2025, at 6:32 a.m., the surveyor observed ULP-D applied TEDs using correct technique to R8's legs. R8's assessment dated June 19, 2025, included: - resident is at risk to be abused- specify measures to minimize risk: resident at risk of abuse related to confusion and not being able to	0 630		

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0 630	Continued From page 13 accurately describe an act of abuse directed toward her. R8's IAPP did not include specific interventions for the identified vulnerability as required. On July 10, 2025, at 10:35 a.m., R7's IAPP was reviewed with CNS-C. CNS-C stated R7's IAPP should have included staff interventions, such as to redirect in calm voice. CNS-C stated R7's IAPP was missing items. On July 10, 2025, at 10:44 a.m., R8's IAPP was reviewed with CNS-C. CNS-C stated R8's IAPP also was lacking specific interventions for R8's noted vulnerabilities. The licensee's Vulnerable Adult Maltreatment policy reviewed November 15, 2023, noted an abuse prevention plan would be completed for each resident in the assisted living by day 14 after move in or receipt of services. The individual abuse prevention plan would: a. be based upon an individualized review or assessment of the resident's i. susceptibility to abuse by another individual including other vulnerable adults ii. risk of abusing other vulnerable adults b. specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 14 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number in common areas of the facility or near telephones provided by the facility. This had the potential to affect residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 7, 2025, at approximately 11:15 a.m., during a tour of the facility with licensed assisted living director (LALD)-B the surveyor did not observe the required posting of 911 emergency number.	0 640		

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0 640	Continued From page 15 On July 7, 2025, at 11:24 a.m., LALD-B stated she did not see the 911 emergency number in the commons area. LALD-B walked into the kitchen to a telephone that was provided by the facility for resident use. LALD-B stated 911 was not posted on or near the telephone either. On July 7, 2025, at 11:27 a.m., LALD-B stated she was not aware of the requirement and confirmed there was no signage of the 911 emergency number on cordless phone, in kitchen near cordless phone, or in the commons area as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 16 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for three of three employees (unlicensed personnel (ULP)-F, ULP-H, clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: TRAINING/COMPETENCY ULP-F ULP-F was hired on October 18, 2023, to provide direct care services to the facility's residents. On July 8, 2025, at 5:42 a.m., the surveyor observed ULP-F cleaning the kitchen at the facility. ULP-F stated she was the only ULP-F working at that time and she only gave PRN (as needed or as desired) medications on the night shift.	0 650		

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0 650	Continued From page 17 ULP-F's employee record included: medication administration-overview completed November 21, 2023 (EduCare/on-line training program). ULP-F's employee record lacked evidence of medication competency completion. ULP-H ULP-H was hired on March 1, 2025, to provide direct care services to the facility's residents. On July 9, 2025, at 5:30 p.m., the surveyor called the facility. ULP-H answered the phone. ULP-H stated she was assisting residents and requested the surveyor called back. ULP-H's employee record lacked evidence of medication administration and competency completion. On July 8, 2025, at 12:10 p.m., CNS-C sated she knew she did the training and competencies for medication administration. CNS-C stated she was not able to find the training in any of the records she reviewed. CNS-C stated ULPs were not allowed to administer medication until she (CNS-C) did the medication training and ULPs were deemed competent. CNS-C stated this was a widespread issue. PERFORMANCE REVIEW CNS-C was hired on October 10, 2023, as the CNS for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On July 7, 2025, at 10:57 a.m., during the entrance conference CNS-C, CNS-C stated the daily staffing schedule was posted.	0 650		

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0 650	Continued From page 18 CNS-C's employee record lacked documentation of annual performance review that identify areas of improvement needed and training needs. On July 8, 2025, at 7:22 a.m., licensed assisted living director/owner (LALD/O)-A stated she did not complete an annual performance review on CNS-C. LALD/O-A stated she was not aware of the requirement. LALD/O-A stated she did complete an annual performance review for ULP-F but added it was done late. LALD/O-A stated she had completed them in the past and would start to complete them again. LALD/O-A confirmed she had not completed yearly performance reviews as required. The licensee's Personnel Records policy reviewed November 15, 2023, noted every employee of the licensee shall have a personnel file created upon hire which shall contain: - record of all required training for unlicensed personnel and competency evaluations - performance evaluations which identify areas of improvement needed and training needs. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the	0 650		

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0 650	Continued From page 19 training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 20 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: POSTED PROMINENTLY On July 7, 2025, at 10:00 a.m., during the entrance conference licensed assisted living director/owner (LALD/O)-A stated the emergency binder should be under the shelve by the door (entrance). On July 7, 2025, at 11:23 a.m., LALD-B stated she located the EPP for the facility, under a shelve in an unlocked room with a sign on the	0 680		

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0 680	Continued From page 21 door that noted: "Restricted Area Staff Only Beyond This Point!" LALD-B stated the facility's EPP was not posted prominently, nor was there any signage in the common's room of the location of the facility's EPP. EPP ANNUL REVIEW On July 7, 2025, at 12:29 p.m., LALD/O-A stated we are "supposed to go through this (EPP) annually. LALD/O-A stated she was not sure if there would be anything in the policy book of the EPPs review. On July 7, 2025, at 12:37 p.m., the surveyor and both LALD's reviewed the facility's EPP binder. LALD-B stated the facility risk assessment was not dated. LALD/O-A stated she "thought" she had it (risk assessment) coming up, as it (risk assessment) was reviewed once a year. LALD/O-A stated the risks at the facility had not "really changed." The facility's Emergency Action Plan was dated April 8, 2022. The Emergency Personnel Names and Phone Numbers document was dated April 8, 2022. The Physical Environment Survey Checklist form was dated October 20, 2023. The licensee's EPP lacked the following content and/or policies and procedures to address: - quarterly review of missing persons policy - a description of the population served by the licensee In addition, the facility's EPP lacked an annual review as required. On July 7, 2025, at 12:40 p.m., the EPP was reviewed with LALD/O-A and LALD-B. LALD-B stated she was not aware of the quarterly review requirement for missing resident. LALD-B stated the licensee's Missing Resident policy was last	0 680		

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0 680	Continued From page 22 reviewed on April 1, 2024. On July 7, 2025, at 1:10 p.m., LALD-B stated she (LALD-B) remembered doing something like identifying the population at risk. LALD-B stated she was not able to locate the identifying of the facility population in the facility's EPP. LALD/O-A stated the facility's EPP lacked to identify the population at risk, to review the missing person policy quarterly, and lacked to post the plan prominently. In addition, LALD/O-A stated all of the facility's policy with the exception of the facility's communication plan needed to be reviewed. The licensee's Develop and Maintain Emergency Preparedness Program policy reviewed April 1, 2024, noted the facility must comply with all applicable Federal, State and local emergency preparedness requirements. The facility must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements. The LTC (long term care) facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The licensee's Emergency and Disaster Preparedness policy reviewed April 1, 2024, noted the facility would post the emergency disaster plan prominently. Further, a written policy and procedure regarding missing residents is complex in compliance with MN Rule 4659.0110. The licensee's Missing Resident policy reviewed October 20, 2023, noted the LALD and clinical nurse supervisor (CNS) would review the missing resident plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 23 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a	0 775		

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0 775	Continued From page 24 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 7, 2025, at 3:00 p.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed the following: OBSTRUCTED EGRESS The egress windows were obstructed by the storage of personal items in front of the windows in occupied resident rooms 1 and 6. The egress window in occupied resident room 4 was obstructed by a shrub on the exterior of the building. During the facility tour interview, LALD/O-A verified the above listed obstructed egress observations. ELECTRIAL - In the basement, covers were not installed on two electrial wall outlets and one wall switch. - Extension cords were used to supply power in occupied resident room 4 and on the exterior at the front entrance. During the facility tour interview, LALD/O-A verified the above listed electrial observations. EMERGENCY EXIT SIGN MAINTENANCE The sticker attached to the illuminated exit sign in the basement indicated annual testing had last been performed in May 2022. During the facility tour interview, LALD/O-A stated they were unsure if this exit sign had been tested in the past year. EXITING An illuminated exit sign was installed at the door leading into the attached garage from the	0 775		

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0 775	Continued From page 25 assisted living dwelling unit. The garage was used for vehicle parking, the storage of gas powered equipment, and storage of facility supplies. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During the facility tour interview, LALD/O-A verified the above listed exiting and storage observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an interconnected smoke alarm in a resident sleeping room that complied with fire protection requirements. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 7, 2025, at 3:00 p.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed the smoke alarm installed on the ceiling in occupied resident sleeping room 7 did not actuate when the other dwelling unit smoke alarms were tested by LALD/O-A. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, LALD/O-A verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790	Continued From page 27	0 790		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 7, 2025, at 3:00 p.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed the following: - In the attached garage, the installed portable fire extinguisher gauge indicated recharge. - The portable fire extinguisher in the kitchen was	0 790		

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0 790	Continued From page 28 stored on the countertop. In the back living room, the portable fire extinguisher was stored on the floor. Fire extinguishers must be properly mounted to prevent them from being moved or damaged. - Monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers indicating monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, LALD/O-A verified the above listed portable fire extinguisher observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 29 failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 7, 2025, at 3:00 p.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed the following: - In occupied resident sleeping room 7, two light bulbs were not working in the ceiling light fixture. - In the shared resident bathroom, the wall surface was not finished behind the sink. During the facility tour interview, LALD/O-A verified the above listed physical environment observations. LALD/O-A stated a new bathroom sink had been recently installed and the licensee was still working on finishing the wall surface. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 30 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and	0 810		

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0 810	Continued From page 31 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 7, 2025, assisted living director/owner (LALD/O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP was a template from a third party provider and had not been developed with site specific procedures for the assisted living facility and the building occupants. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. Fire doors were referenced but not identified. Smoke doors were inaccurately referenced. The FSEP inappropriately directed employees in the event of a large scale fire, the fire department may order evacuation of the facility. These evacuation procedures were developed for a	0 810		

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0 810	Continued From page 32 building with life safety systems and a fire resistant construction type that were not applicable to this building. The FSEP failed to include fire safety and evacuation instructions for residents, evident by the lack of written procedures in the plan. The FSEP failed to include site specific resident evacuation procedures, that included procedures for resident movement and/or relocation during a fire or similar emergency. Small exit labels that were difficult to read were used to identify exit doors on the posted FSEP floor plan. Exit doors are required to be clearly labeled on the FSEP floor plan in order to direct the building occupants to these exits in the event of an emergency. During an interview on July 7, 2025, at 5:05 p.m., LALD/O-A verified the FSEP required revision. The FSEP failed to include evacuation procedures for the individualized unique needs of residents. During an interview on July 7, 2025, at 5:05 p.m., LALD/O-A stated the evacuation procedures for the individualized unique needs of residents had not been identified. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a lack of documentation to support this training had been completed. The surveyor requested resident training records for the past year from LALD/O-A. No records were provided. During an interview on July 7, 2025, at 5:05 p.m., LALD/O-A verified the resident training frequency was not met.	0 810		

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0 810	Continued From page 33 Record review indicated the licensee failed to provide training to all employees on the FSEP at least twice per year evident by a lack of documentation to support this training had been completed. One record was provided for an employee meeting dated June 24, 2024. This record listed emergency procedures and fire drills as training topics, with five employees recorded as attending. During an interview on July 7, 2025, at 5:05 p.m., LALD/O-A verified the employee FSEP training frequency was not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill reports lacking the required frequency. One fire drill was recorded in 2025, dated February 14th. Five fire drills were recorded in 2024, dated January 25th, March 20th, May 17th, June 24th, and August 22nd. Fire drill reports indicated no overnight drills had been completed in the past year. During an interview on July 7, 2025, at 5:05 p.m., LALD/O-A verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim	0 950		

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0 950	Continued From page 34 notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R7, R8) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 950		

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0 950	Continued From page 35 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: R7 R7 was admitted to the facility on May 22, 2025. On July 8, 2025, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R7's morning medication using correct technique. R7's Resident Agreement dated May 22, 2025, noted: -Designated Representative (name/contact) -if resident declines to name a Designated Representative, Resident please initial here: (initialed). R7's record included a service plan dated July 7, 2025 (printed date), un-authenticated noted: -Right to Designate a Representative for Certain Purposes: you have the right to name anyone as your "designated Representative". A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable. -line for resident initials, resident declines to name a Designated Representative. R7's Assisted Living Resident Agreement lacked	0 950		

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0 950	Continued From page 36 the required statutory verbiage for designated representative, and R7's service agreement had not been signed/ presented to R7. R8 R8 was admitted to the facility on August 26, 2014. On July 8, 2025, at 6:32 a.m., the surveyor observed ULP-D apply compression hose (TEDs) to R8's legs using correct technique. R8's service plan dated February 23, 2022, included: - Designated Representative: (blank line) resident declines to name a Designated Representative. On July 8, 2025, at 9:20 a.m., the surveyor reviewed the Resident Agreement and service plan template currently used at the facility with licensed assisted living director/owner (LALD/O)-A. LALD/O-A stated the required statutory verbiage was not in the current Resident Agreement and R7 did not sign or see the service plan that contained the required verbiage. LALD/O-A confirmed resident's records lacked the required verbiage, and/or the residents were not given the document which noted the required verbiage. On July 10, 2025, at 10:35 a.m., LALD/O-A stated she did not do anything with resident's service plans. LALD/O-A stated residents do not see/receive the required verbiage in regard to designated representative. LALD/O-A stated it was a widespread issue. No further information was provided. TIME PERIOD FOR CORRECTION:	0 950		

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0 950	Continued From page 37 Twenty-One (21) days	0 950		
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	01060		

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01060	Continued From page 38 (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: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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's diagnosis included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior). R1's unauthenticated service plan dated June 26, 2025, indicated R1 received the following services: blood pressure, pulse, weight, and oxygen monitoring daily, oxygen maintenance,	01060		

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	30235	A. BUILDING: _____ B. WING _____	07/10/2025

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01060	Continued From page 39 medication administration, grooming, ambulation/exercise assist, mouth care, support stockings, symptom screening, and housekeeping services. R1's record included a resident note dated January 18, 2025: 911 called -staff arrived to find resident sitting on side of bed. Vitals were taken: oxygen 91, pulse 63, blood pressure 123/55. Resident was twitching and grabbing at things in the air that were not there. He was disoriented. Staff called 911. Resident contained (sic) to sit on sit (sic) of bed and drinking a bottle of water. Stated he was thirsty. Staff left to complete a referral to the ER (emergency room) and a few minutes later another staff came in and stated resident was on the floor in the hallway. Resident stated he was going to the bathroom and fell-slid down the wall into a sitting position. Other staff member took vitals. Paramedics arrived within a few minutes of the incident. Resident was taken to the ER at [hospital] to be evaluated. R1's record included a resident note dated January 21, 2025: hospitalization update - resident continues to be in hospital and fighting. His sister came by and picked up a few of his belongings this afternoon. R1's record included a resident note dated January 24, 2025: resident passed -residents sister informed staff that he had passed away due to complications of COPD (chronic inflammatory lung disease/ causes obstructed airflow from the lungs), Influenza A and double pneumonia. On July 7, 2025, at 10:42 a.m., the licensee's discharge roster was reviewed with clinical nurse	01060		

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01060	Continued From page 40 supervisor (CNS)-C which included: (R1) dated of discharge or death: January 22, 2025 - hospital - was termination of services notice provided n/a (not applicable). The surveyor asked CNS-C how long R1 has been out of the facility and if the required notification had been completed. CNS-C stated R1 had the flu and Covid and had passed away. CNS-C stated she (CNS-C) did not fill out the paperwork but licensed assisted living director/owner (LALD/O)-A had completed the required paperwork. R1's record lacked a written notice that contained, at a minimum: - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - known and applicable, the approximate date or range of dates within which the resident was 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. On July 7, 2025, at 11:35 a.m., LALD/O-A stated she did not fill out any relocation paperwork as R1 had been admitted to the hospital. LALD/O-A stated she had not understood the requirement and had not sent in the required paperwork for hospital admissions. The licensee's Contract Termination policy reviewed September 19, 2024, noted in the event	01060		

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01060	Continued From page 41 of an emergency relocation, the facility must provide a written notice that contained, at a minimum: 1. the reason for the relocation 2. the name and contact information for the location to which the resident had been relocated and any new service provider 3. contact information for the Office of Ombudsman for Long-Term Care 4. if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known, and 5. a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. 6. the notice required would be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. for residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained	01420		

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01420	Continued From page 42 in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency demonstration by the registered nurse (RN) was completed for three of three unlicensed personnel (ULP-F, ULP-H, ULP-G). Additionally, the licensee failed to provide written instructions in one of one resident record (R2) for delegated tasks to include personal alarms. 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: R2's diagnoses included chronic low back pain, repeated falls, anemia (low red blood cells that carry oxygen/ causing tiredness and shortness of breath), cardiovascular accident (CVA- stroke),	01420		

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01420	Continued From page 43 and hypertension (high blood pressure/HTN). R2's non-authenticated service plan, printed July 8, 2025, indicated R2 received the following services: incontinence care, shaving assist, mouth care, toileting, safety checks, skin care, and housekeeping services. On July 7, 2025, at 5:47 a.m., the surveyor observed an alarm (pressure type) positioned on a recliner in the living area/commons area. Unlicensed personnel (ULP)-F stated that was where R2 sat, and the alarm "beeped" if/when R2 attempted to self-transfer. ULP-F stated R2 had an alarm in his bed also. TRAINING ULP-F ULP-F was hired on October 18, 2023, to provide direct care services to the facility's residents. ULP-F's record lacked evidence of any training or competency for R2's alarms. ULP-H ULP-H was hired on March 1, 2025, to provide direct care services to the facility's residents. ULP-H's record lacked evidence of any training or competency for R2's alarms. On July 9, 2025, at 5:30 p.m., the surveyor called the facility. ULP-H answered the phone. ULP-H stated she and ULP-G were assisting residents and requested the surveyor call back. On July 9, 2025, at 7:13 p.m., ULP-H stated clinical nurse supervisor (CNS)-C did not train her (ULP-H) on R2's alarm. ULP-H stated licensed assisted living director/owner (LALD/O)-A trained	01420		

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01420	Continued From page 44 her (ULP-H) on R2's alarms. On July 10, 2025, at approximately 10:00 a.m., LALD/O-A stated ULP-H must have been confused and thought that when LALD/O-A worked with R2's alarm LALD/O-A taught ULP-H how to use R2's alarm. ULP-G ULP-G was hired on March 21, 2025, to provide direct care services to the facility's residents. ULP-G's record lacked evidence of any training or competency for R2's alarms. On July 9, 2025, at 7:10 p.m., the surveyor called and spoke to ULP-G who was working at the facility. ULP-G stated CNS-C did not train her on R2's alarms. On July 7, 2025, at 11:50 a.m., CNS-C stated "we (herself and ULP) talk about alarm use, "I tell them there is an alarm" CNS-C stated ULPs were not "trained" and no competencies were completed with alarm use. NECESSARY INSTRUCTIONS R2's record lacked written instructions delegated by the RN to ULPs related to use and the working condition of R2's personal alarms, or when to notify the RN if issues arise. On July 7, 2025, at 12:08 p.m., R2's record was reviewed with CNS-C. CNS-C stated R2's record lacked evidence of any mention of R2's alarm use as required. CNS-C stated R2 was the only resident for whom an alarm was used. CNS-C stated there were not any other delegated tasks performed at the facility.	01420		

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01420	Continued From page 45 The licensee's Delegation of Nursing Tasks policy reviewed November 15, 2023, noted before delegating or assigning a task to unlicensed personnel, the CNS/RN must determine that each staff member who will perform the task is trained and competent to perform the task and has been instructed in the proper procedures for performing the procedures with resident for the specific resident. The CNS/RN will assure that training and competency records for all unlicensed staff are kept up-to-date and are easily accessible to the CNS/RN can determine which staff is competent to perform various delegated tasks. Further, the CNS/RN would developed specific written instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (clinical nurse supervisor (CNS)-C), received the required amount of dementia, mental illness, and	01490		

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01490	Continued From page 46 de-escalation training required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on October 10, 2023, as the CNS for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-C's employee record lacked documentation of dementia training, mental illness, and de-escalation training. On July 7, 2025, at 2:47 p.m., licensed assisted living director (LALD)-B stated she had assigned all of the required training to CNS-C however CNS-C had not completed any of the required training. LALD-B confirmed CNS-C's annual dementia training was not completed as required. The licensee's Assisted Living Dementia Training policy reviewed November 15, 2023, noted assisted living staff would receive required training on dementia care during orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		

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

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01500	Continued From page 48 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-F). 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: CNS-C	01500		

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01500	Continued From page 49 CNS-C was hired on October 10, 2023, as CNS for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: - training on reporting of maltreatment of vulnerable adults - overview of Assisted Living Bill of Rights - review of infection control techniques - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 7, 2025, at 2:47 p.m., licensed assisted living director (LALD)-B stated she had assigned all of the required annual training to CNS-C however CNS-C had not completed any of the required training. LALD-B confirmed CNS-C's annual training was not completed as required. ULP-F ULP-F was hired on October 18, 2023, to provide direct care services to the facility's residents. On July 7, 2025, at 5:47 a.m., the surveyor observed an alarm positioned on a recliner in the living area/commons area. The surveyor pointed to the alarm in the recliner and ULP-F stated that was where R2 sat and the alarm "beeped" if/when	01500		

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01500	Continued From page 50 R2 attempted to self-transfer. ULP-F stated R2 had an alarm in his bed also. ULP-F's employee record lacked evidence ULP-F successfully completed annual training as required to include: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On July 8, 2025, at 7:22 a.m., LALD/owner (O)-A stated policies were reviewed at hire and if there was a new policy. LALD/O-A stated she did not have ULPs review the facility's policies annually as required. The licensee's Annual Required Staff Training policy dated reviewed November 16, 2023, noted all assisted living employees would complete annual education on the following topics: - reporting of maltreatment of vulnerable adults under section 626.557 - assisted living bill of rights - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and the use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - effective approaches for problem solving when working with a resident's challenging behaviors - effective approaches for communication with residents who have dementia, Alzheimer's disease, or related disorders - review of the facility's policies and procedures	01500		

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01500	Continued From page 51 relating to the provision of assisted living services and how to implement those policies and procedures - principles of person-centered planning and service delivery - emergency and disaster training. Direct-care staff would complete eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160	01530		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 52 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (clinical nurse supervisor (CNS)-C), received the required amount of annual dementia care training and training on topics required in the time frame required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01530		

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	30235	A. BUILDING: _____ B. WING _____	07/10/2025

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01530	Continued From page 53 CNS-C was hired on October 10, 2023, as CNS for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On July 7, 2025, at 10:57 a.m., during the entrance conference CNS-C, CNS-C stated the daily staffing schedule was posted. CNS-C's record lacked evidence of at least two hours of training on topics related to dementia and one hour of training on topic related to mental illness and de-escalation as required. On July 7, 2025, at 4:06 a.m., licensed assisted living director (LALD)-B stated CNS-C had some dementia training but was not sure if the" mental illness piece got added." LALD-B looked in CNS-C's employee record and stated she would need to add/assign the training to CNS-C. In addition, LALD-B stated CNS-C had not completed two hours of dementia training annually. The licensee's Assisted Living Dementia Training policy reviewed November 15, 2023, noted assisted living staff would receive required training on dementia care during orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01565 SS=C	144G.64 (c) Training in Dementia, Mental Illness, and De-	01565		

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01565	Continued From page 54 (a)The facility shall provide to consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered to include mental illness and de-escalation as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 30, 2025, at 8:16 a.m., R7's record was reviewed with licensed assisted living director (LALD)-B. LALD-B stated the licensee did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers to include mental illness and de-escalation as required. LALD/owner (O)-A stated that information would be made available in the future, but it currently was not available as	01565		

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01565	Continued From page 55 required, as the licensee had not updated the form used. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01565		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

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01620	Continued From page 56 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 14 days for one of one resident (R7) and did not exceed 90 days for one of one resident (R6). In addition, the licensee failed to ensure the RN completed an alarm assessment for one of one resident, (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01620		

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01620	Continued From page 57 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: 14 DAY ASSESSMENT R7 R7 was admitted to the facility on May 22, 2025. R7's diagnosis included alcohol use disorder, anxiety, and suicidal ideation. R7's record did not include a signed service plan. On July 8, 2025, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R7's morning medication using correct technique. R7's most recent assessment was dated May 22, 2025. R7's record lacked a 14-day assessment, (assessment due on or before June 3, 2025.) On July 8, 2025, at 11:16 a.m., clinical nurse supervisor (CNS)-C stated she did not know that an "official" 14-day assessment was required. CNS-C stated she "checks on them (residents), but there was no evidence of that (check in/14-day assessment) in residents' records. 90 DAY ASSESSMENT R6 R6 was admitted to the facility on August 5, 2022. R6's diagnoses schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior).	01620		

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01620	Continued From page 58 R6's un-authenticated service plan dated June 26, 2025, indicated R6 received assistance with toileting, ambulation/exercise, behavior management, dressing, and housekeeping services. On July 7, 2025, at 12:14 p.m., the surveyor observed ULP-D take a salad to R6's room for lunch. ULP-D encouraged R6 to sit on the side of the bed to eat the salad. R6's most current assessment was dated February 5, 2025, (assessment due on or before May 6, 2025). On July 7, 2025, at 12:33 p.m., the surveyor requested R6's most current assessment. CNS-C stated the assessment dated February 5, 2025, was R6's most current assessment. CNS-C stated the computer system used by the licensee should have "flagged her" (notified CNS-C) a 90-day assessment was required. CNS-C confirmed R6's 90-day assessment had not been completed as required. ALARM ASSESSMENT R2 R2's diagnoses included chronic low back pain, repeated falls, anemia (low red blood cells that carry oxygen/ causing tiredness and shortness of breath, cardiovascular accident (CVA- stroke), and hypertension (high blood pressure). R2's record did not include a signed service plan. R2's assessment dated May 17, 2025, included: - mobility- ambulation: needs occasional supervision/standby help and supervision to walk - mobility- transfer: needs supervision to ensure safety when transferring, unsteadiness	01620		

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01620	Continued From page 59 - mobility- bed: independent with bed mobility - manage environment: needs help reducing fall risk by removing clutter in apartment - gait/balance: balance problem while standing, while walking, unable to rise from a chair at nee height - general safety: is able to activate emergency call system - fall risk summary: staff to provide safety checks every two hours and provide standby assistance while he is ambulating with wheeled walker. Remind resident to use call light for assistance. Keep room tidy and free of clutter to prevent trips/falls. Ensure resident has non-slip footwear on before transferring or ambulating. On July 7, 2025, at 5:47 a.m., the surveyor observed an alarm (pressure type) positioned on a recliner in the living area/commons area. Unlicensed personnel (ULP)-F stated that was where R2 sat and the alarm "beeped" if/when R2 attempted to self-transfer. ULP-F stated R2 had an alarm in his bed also. On July 7, 2025, at 6:02 a.m., the surveyor observed ULP-D enter R2's room and asked R2 how R2 slept. The surveyor heard an alarm sound as ULP-D assisted R2 to a sitting position. R2's assessment lacked evidence of the need/use of an alarm. On July 8, 2025, at 12:32 p.m., CNS-C reviewed R2's record. CNS-C stated she "could have sworn it (alarm assessment) was in there (R2's record)." CNS-C stated licensed assisted living director/owner (LALD/O)-A told her to do an assessment on R2's alarm. CNS-C stated only one resident used an alarm and it was "odd" that it was not in R2's assessment. CNS-C confirmed	01620		

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01620	Continued From page 60 R2's assessment did not include the use/need of an alarm as required. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Facility policy reviewed November 15, 2023, noted a CNS/RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: - pre-admission assessment - 14-day assessment: completed up to 14 days after start of services - ongoing assessment: completed periodically but no less than every 90 days - change in resident condition. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided.	01620		

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01620	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were authenticated to confirm agreement of the services to be provided for two of two residents (R7, R2). In addition, the licensee failed to ensure service plans were revised to include provided services for two of two residents (R8, R2).	01640		

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01640	Continued From page 62 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 7, 2025, at 10:34 a.m., during the entrance conference with licensed assisted living director/owner (LALD/O)-A and clinical nurse supervisor (CNS)-C, LALD/O-A stated the RN (registered nurse/CNS) completed the service plans and LALD/O-A added to the service plans. CNS-C stated service plans then go out to the staff (unlicensed personnel /ULP) and ULP lets the licensee know if changes are needed. AUTHENTICATED SERVICE PLAN R7 R7 was admitted to the facility on May 22, 2025. R7's diagnosis included alcohol use disorder, anxiety, and suicidal ideation. On July 8, 2025, at 8:07 a.m., the surveyor observed ULP-E administer R7's morning medication using correct technique. On July 8, 2025, at 10:55 a.m., the surveyor requested R7's service plan and was given a service plan dated July 8, 2025 (one day after survey entrance) which was not authenticated by the resident or resident's representative or by the facility's representative. CNS-C stated that was what she (CNS-C) had for R7's service plan.	01640		

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01640	Continued From page 63 R7's record did not include a signed service plan. On July 8, 2025, at 10:58 a.m., CNS-C stated, "just so you know, someone else was doing the service plans." R2 R2 was admitted to the facility on February 2, 2024. R2's diagnoses included chronic low back pain, repeated falls, anemia (low red blood cells that carry oxygen/ causing tiredness and shortness of breath, cardiovascular accident (CVA- stroke), and hypertension (high blood pressure/HTN). On July 7, 2025, at 5:47 a.m., the surveyor observed an alarm (pressure type) positioned on a recliner in the living area/commons area. ULP-F stated that was where R2 sat, and the alarm "beeped" if/when R2 attempted to self-transfer. ULP-F stated R2 had an alarm in his bed also. On July 8, 2025, at 12:55 p.m., the surveyor requested R2's service plan and was given a service plan dated July 8, 2025 (one day after survey entrance) which was not authenticated by the resident or resident's representative or by the facility's representative. CNS-C stated that was what she had for R2's service plan. R2's record did not include a signed service plan. REVISIONS TO SERVICE PLANS R8 R8's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), Alzheimer's disease, chronic fatigue, and	01640		

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01640	Continued From page 64 developmental disability. R8's service plan dated February 22, 2022, indicated R8 received daily temperatures, symptom screening (Covid) daily, support stockings (compression stockings) twice daily, dressing assist, grooming assist, incontinence care, medication administration: two days a week and four times per day, daily oxygen saturation, and housekeeping services. On July 8, 2025, at 6:32 a.m., the surveyor observed ULP-D apply compression stockings (TEDs) to R8's legs using correct technique. R8's prescriber's order dated June 6, 2025, included: - medication administration three times daily - temperature: monthly. On July 8, 2025, at 10:26 a.m., R8's service plan was reviewed with CNS-C. CNS-C stated she prints them (service plans) out and then she has staff review the service plans to make sure they were correct. CNS-C stated that was an old service plan as it had Covid monitoring on it. CNS-C stated she would look to see if there was a newer service plan for R8. CNS-C stated she did not find an updated service plan for R8. R2 R2's unsigned service plan dated effective July 8, 2025, indicated R2 received incontinence care, medication administration three times daily, mouth care, safety checks three times daily, stand-by assist with ambulation, toileting assistance, and housekeeping services. R2's service plan was not revised to include alarm use.	01640		

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01640	Continued From page 65 On July 8, 2025, at 12:32 p.m., R2's service plan was reviewed with CNS-C. CNS-C stated R2's alarm or fall precaution service was not in R2's service plan. CNS-C stated she thought she did an alarm assessment per LALD/O-A request and the assessment would have triggered the service of an alarm. CNS-C confirmed R2's service plan was not revised as required. On July 10, 2025, at 10:35 a.m., LALD/O-A stated she did not do anything with resident's service plans. LALD/O-A stated resident's service plans (authentication and revisions) were widespread issue. The licensee's Contents of Service Plans policy reviewed November 16, 2023, noted a finalized service plan would be completed no later than 14 calendar days after initiation of services. Service plans and nay revisions to services plans would have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. Service plans are reviewed and revised as needed based upon on-going resident assessment. The initial review must be completed within 30 calendar days of the start of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750		

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BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(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
01750	Continued From page 66 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP) in the proper methods to administer medications, and ULP had demonstrated the ability to competently follow the procedures for administering medications, for three of three ULP (ULP-F, ULP-H, ULP-G). This had the potential to affect all residents receiving assisted living services. In addition, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01750		

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01750	Continued From page 67 The findings include: R7 R7's diagnosis included alcohol use disorder, anxiety, and suicidal ideation. R7's record included standing orders dated June 6, 2025, that included: - Dulcolax suppository (inserted into the rectum) one every day rectal PRN (as desired or as needed) for constipation - Fleets enema (process to push waste out of rectum) one everyday PRN for constipation. MEDICATION ADMINISTRATION/ TRAINING & COMPETENCY ULP-F ULP-F was hired on October 18, 2023, to provide direct care services to the facility's residents. On July 8, 2025, at 5:42 a.m., the surveyor observed ULP-F cleaning the kitchen at the facility. ULP-F stated she was the only ULP-F working at that time and she only gave as needed (PRN) medications on the night shift. ULP-F's record included a certificate of completion dated November 21, 2023, for medication administration-overview. ULP-F's record did not include any competency for medication administration, however clinical nurse supervisor (CNS)-C stated ULP-F and all ULP's were trained and were deemed competent to give medications prior to working at the facility. On July 8, 2025, at 12:50 p.m., ULP-F stated she "thought" she had been trained on enemas. On July 9, 2025, at 7:26 p.m., ULP-F stated CNS-C "talked to her" about enemas. ULP-F	01750		

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01750	Continued From page 68 stated she did not do a return demonstration or explain to CNS-C how she (ULP-F) would do an enema. ULP-F stated she asked about enemas since there was one the medication closet. ULP-F could not remember if she was talked to or trained to do suppositories. ULP-H ULP-H was hired on March 1, 2025, to provide direct care services to the facility's residents. On July 9, 2025, at 7:13 p.m., ULP-H stated CNS-C trained her to "administer medications and that was about it." ULP-H stated she could not remember if CNS-C trained her to do suppositories or enemas. ULP-G ULP-G was hired on March 21, 2025, to provide direct care services to the facility's residents. On July 9, 2025, at 7:10 p.m., the surveyor called and spoke to ULP-G who was working at the facility. ULP-G stated CNS-C did not train her to give enemas or suppositories. On July 8, 2025, at 1:07 p.m., CNS-C stated she was ready to do a complete training and competency on a recent hire and that hire never showed up. CNS-C stated she reviewed ULP-D's file as she (ULP-D) had been here the longer and there was no training for the above items documented. CNS-C added knows she did not train on enemas. CNS-C confirmed ULPs did not have the training and were deem competent for delegated medication administration, such as enemas. On July 8, 2025, at 11:50 a.m., the surveyor and CNS-C reviewed the Standing Orders for the	01750		

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01750	Continued From page 69 facility. CNS-C stated that list (standing orders) needed to be reviewed as it was no longer current. CNS-C stated, "the first ones (ULPs) were taught (trained)," but CNS-C stated she was not sure if all ULPs were trained to give suppositories or enemas. CNS-C confirmed the task of medication administration for rectum medications had been delegated to ULPs and there was no evidence of the training or competencies. SPECIFIC INSTRUCTIONS On July 8, 2025, at 8:07 a.m., the surveyor observed ULP-E administer R7's medication, (to include tamsulosin (prostate/enlarged) and eye solution) using correct technique. R7's medication administration record (MAR) dated July 1, 2025, through July 7, 2025, included: -brimonidine eye solution 0.2 % (high eye pressure) instill one drop into both eyes three times daily, 8:00 a.m., 2:00 p.m., 8:00 p.m. -dorzolamide/timolol solution 2-0.5 % (high eye pressure) instill one drop into both eyes twice daily, 8:30 a.m., 7:00 p.m. -latanoprost solution 0.005% (high eye pressure) instill one drop into both eyes at bedtime, 10:00 p.m. -tamsulosin capsule 0.4 milligrams (mg) take one capsule by mouth every morning, swallow whole do not crush, chew, or open, by mouth one time a day, 8:00 a.m. R7's prescriber's orders dated June 6, 2025, included the above orders. R7's MAR did not include specific instruction to include manufacturer's instructions.	01750		

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01750	Continued From page 70 On July 8, 2025, at 8:27 a.m., ULP-D stated R7 had not eaten breakfast yet. ULP-D stated R7 waits for his first eye drop and then sits down and eats. On July 8, 2025, at 8:30 a.m., ULP-E stated R7's MAR did not instruct ULPs to wait in-between eye solutions, rather the medications were staggered. ULP-E added there was a buffer to give medications, so 8:30 medication could be administered anytime between 7:30 a.m. and 9:30 a.m. ULP-E stated it was possible to give medications together, however ULP-E stated R7 liked to have one drop administered and then he wanted to eat and then he had his second drop administered. ULP-E stated not all residents made their wishes known as R7 did, and it was possible that ULP could administer the eye drops at the same time. On July 8, 2025, at 11:19 a.m., CNS-C reviewed R7's MAR and manufacturer's instruction for eye solutions (wait times) and for tamsulosin. CNS-C stated R7's record lacked to include specific instructions. The manufacturer's instruction for brimonidine eye solution dated October 2020, noted if you are using in combination with another eye drop medicine, wait 5-15 minutes before applying the second eye drop. The manufacturer's instruction for dorzolamide/timolol solution dated October 2022, noted if you use this eye drop with another eye drop, leave at least ten minutes between putting in dorzolamide/timolol eye drops and the other medicine. The manufacturer's instruction for latanoprost	01750		

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01750	Continued From page 71 solution dated February 1, 2023, noted if you will be using latanoprost with other eye medicines, use them at least five minutes apart from each other. The manufacturer's instruction for tamsulosin capsule dated January 15, 2018, noted take tamsulosin 30 minutes after the same meal each day. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy reviewed June 11, 2024, noted unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the CNS/RN. In addition, the CNS/RN has developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01750		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to	01790		

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01790	Continued From page 72 the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed	01790		

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01790	Continued From page 73 personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-G) and all other ULPs were trained and had demonstrated competency for the procedure of medications for residents having unplanned time away. Further, the licensee failed to ensure the registered nurse (RN) developed a comprehensive written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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 July 7, 2026, at 10:35 a.m., clinical nurse supervisor (CNS-C) stated the licensee provided medication management services. TRAINING AND COMPETENCY EVALUATIONS ULP-G was hired on March 21, 2025, to provide	01790		

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01790	Continued From page 74 direct care services to the facility's residents. On July 9, 2025, at 7:10 p.m., the surveyor called and spoke to ULP-G who was working at the facility. ULP-G stated she and ULP-H were the two ULPs at the facility for the afternoon shift. ULP-G's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On July 8, 2025, at 11:57 a.m., CNS-C stated, I know they (ULP) go and get medications ready, but CNS-C stated she did not do any training on unplanned time away medication. On July 9, 2025, at 7:12 p.m., ULP-G stated she was not trained on unplanned medication. ULP-G stated she would call CNS-C and ask what CNS-C would like her (ULP-G) to do in regard to unplanned time away medication. On July 8, 2025, at 1:40 p.m., licensed assisted living director/owner (LALD/O)-A stated "we (licensee/facility) are so far out (location of facility), we only have one family member that may take out a resident (implied service would not be used). LALD/O-A stated ULPs were not trained on unplanned time away medications. WRITTEN PROCEDURE On July 8, 2025, at 12:08 p.m., the surveyor reviewed the licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Resident Time Away From Home policy with LALD/O-A. LALD/O-A stated the licensee had no written instruction (no written procedure) for unplanned time away medications.	01790		

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01790	Continued From page 75 The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy reviewed October 15, 2023, noted only ULP that had been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven days of medication. ULP would contact the CNS on-call upon notification by resident or family of plans to be absent during medication administration times to seek directions. (special instructions may include the need for the CNS to talk to the resident or resident's representative, instructions for storage, or for controlled substances) - review the medication administration record to determine the medications that will need to be sent with the resident - obtain medications that will be needed for planned leave of absence - obtain cover letter from CNS with contact information and the following information: a. the name of the person that received the medications and instructions b. the time and date the medications were given to that person c. the name of number of each medication given and d. the name and title of the staff person who gave the mediations to the resident or resident's representative - document the medication given in format required by facility by medications, dose, quantity and name of individual to whom the mediation was given - request signature from resident and/or resident's representative signature to dates	01790		

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01790	Continued From page 76 receipt of information on facility specific form - upon return the assisted living facility, obtain unused or refused medications from the resident or resident's representative - document the name and quantity of medication returned upon facility approved from or electronic medication record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01880		

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01880	Continued From page 77 The findings include: R7's diagnoses included alcohol use disorder, anxiety, and suicidal ideation. R7's record did not include a signed service plan. R7's unauthenticated service plan template dated July 8, 2025, included: -medication administration seven times per day. On July 8, 2025, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R7's morning medication using correct technique. R7 requested to take only one medication and refused the rest. The surveyor observed several bottles of vitamins, a container of ear wax remover and a contain of antacid tablets on R7's table, unsecured. R7's assessment dated May 22, 2025, included: - staff at the facility (name) to administer medications - needs full assistance with ordering monthly medication, medication set up, reminders, new medication orders, and ensuring all medications taken and swallowed - keep eyes on resident when taking medication to ensure medication taken and swallowed - staff must physically assist resident in taking all mediations and in maintaining records for the resident - all medication are locked. All controlled medications are double locked, counted when administered and counted by two staff at change of shift - ear drops, eye drops, inhaler, nasal, oral, topical, transferal, are medication management tasks that maybe delegated to ULP - medication self-administration is not applicable.	01880		

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01880	Continued From page 78 On July 8, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-C stated she was not aware R7 had medications in his (R7's) room. CNS-C stated when "we" (licensee) "see" medications, the medications are removed. On July 8, 2025, at 11:27 a.m., the surveyor reviewed R7's medication assessment with CNS-C. CNS-C stated R7 brought in the medications and would not give the medications up. CNS-C stated R7 should not have medications in his room unsecured. The surveyor and CNS-C went to R7's room and observed: - about half a bottle of milk thistle, 175 milligrams (mg) (supplement/liver disorder, gall bladder issues) - opened eye health ultra (vitamin) - almost gone container of CoQ 10 200 mg (supplement), - about half a container of magnesium 250 mg (supplement) - opened bottle of ear wax remover - about a quarter of a container of antacid tablets. On July 8, 2025, at 11:30 a.m., CNS-C stated the medications in R7's room should have been secured. The licensee's Storage of Medications policy reviewed October 1, 2023, noted a registered nurse (RN) must conduct a face-to-face nursing assessment of a resident need for medication management services, including the appropriate method to store the resident's mediations and whether secure storage was appropriate given the resident's functional and cognitive status, concern about the potential for drug diversion or other considerations. Based on this assessment, the CNS/RN would develop an individualized	01880		

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01880	Continued From page 79 medications management plan for the resident that would address storage of the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for five of five residents (R7, R3, R6, R5, R2). In addition, the licensee failed to monitor for expired medication for one of five residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	01890		

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01890	Continued From page 80 The findings include: On July 7, 2025, at 11:07 a.m., the locked medication storage area was reviewed with clinical nurse supervisor (CNS)-C. CNS-C observed and confirmed the following: TIME SENSITIVE MEDICATION -R7's opened latanoprost 125 micrograms (mcg) 2.5 milligrams (mg) (eye high pressure) eye solution lacked an opened or an expiration date as required -R4's opened Trelegy Ellipta inhaler 200 mcg, 62.5 mcg (wheezing or shortness of breath) included a label that noted to write expiration date here, which was blank. PRESCRIPTION LABEL -R6's opened triamcinolone 0.05% (variety of skin conditions such as eczema, dermatitis, allergies, rash) cream lacked a pharmacy label. R6's triamcinolone cream was labeled only with R6's name -R5's opened TobraDex eye solution (eye infections or inflammation) lacked a pharmacy label as required. R5's TobraDex was labeled only with R5's name. CNS-C stated R5's TobraDex should have been in a bag that included the required information -R2's opened melatonin 3 mg (sleep) bottle lacked a pharmacy label as required. R2's melatonin was labeled only with R2's name. EXPIRED MEDICATION -one opened triamcinolone 0.05 % cream for R7 expiration dated August 2, 2023. CNS-C stated R7's triamcinolone cream should have been removed from the medication bin.	01890		

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01890	Continued From page 81 On July 7, 2025, at 11:20 a.m., CNS-C stated she did not think she told unlicensed personnel (ULP) to date time sensitive medications. CNS-C added in the clinic time sensitive medications were not an issue (CNS-C's work history). CNS-C stated the dating time sensitive medication and having the required information on medication was a widespread issue. The manufacturer's instruction for latanoprost dated February 1, 2023, noted you may keep the opened bottle in the refrigerator or at room temperature for up to six weeks. The manufacturer's instruction for Trelegy Ellipta dated January 14, 2024, noted discard Trelegy Ellipta six weeks after you have taken it out of the foil pouch, or if the dose indicator shows a zero, whichever comes first. The licensee's Storage of Medications policy reviewed October 1, 2023, noted: - an over-the-counter drug must be kept in the original labeled container from the pharmacy - until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time- dated drug, directions for use, resident's name, prescriber's name, dale of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01950	Continued From page 82	01950		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) and had ULP demonstrate the ability to follow the procedure for three of three employees (ULP-F, ULP-H, ULP-G). Additionally, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R8) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01950		

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01950	Continued From page 83 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 7, 2026, at 10:43 a.m., clinical nurse supervisor (CNS-C) stated the licensee currently provided treatment/therapy services to include compression stockings (TEDs). CNS-C added no current resident received the service of scheduled blood glucose monitoring. R8's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), Alzheimer's disease, chronic fatigue, and developmental disability. R8's service plan dated February 23, 2022, indicated R8 received assist with support stockings (TEDs), dressing, grooming, incontinence care and bathing assistance. R8's record included: support stocking a.m. (morning) cares, active February 22, 2020, assigned to a.m.: - instructions: assist resident to get support stockings on each morning support stocking bedtime cares, active February 22, 2020, assigned to p.m., cares and medication assignment, scheduled daily at bedtime - remove pressure stocking at night. R8's prescriber order dated June 6, 2025,	01950		

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01950	Continued From page 84 included the above order for support stockings. R8's standing orders dated June 6, 2025, included: - K-pad or warm pack to affected area PRN (as desired or as needed) - glucose monitoring PRN for symptoms suspicious of hyper/hypoglycemia; follow established protocols. The facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) template dated June 25, 2024, included the following services: - TEDs - diabetic care: blood glucose monitoring. TRAINING & COMPETENCY ULP-F ULP-F was hired on October 18, 2023, to provide direct care services to the facility's residents. On July 8, 2025, at 5:42 a.m., the surveyor observed ULP-F cleaning the kitchen at the facility. ULP-F stated she was the only ULP-F working at that time, night shift. ULP-F stated she sometimes gave PRNs (medications/treatments). ULP-F's record lacked evidence of training or competency for TEDs, K-pad/ warm pack, or glucose monitoring. ULP-H ULP-H was hired on March 1, 2025, to provide direct care services to the facility's residents. On July 9, 2025, at 5:30 p.m., the surveyor called the facility. ULP-H answered the phone. ULP-H stated she was assisting residents and requested the surveyor call back.	01950		

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01950	Continued From page 85 On July 9, 2025, at 7:13 p.m., ULP-H stated CNS-C trained her to administer medications and that was "about it." ULP-H stated she was not trained to do TEDs or warm packs/K-pads. ULP-H's record lacked evidence of training or competency for TEDs, K-pad or warm pack, or glucose monitoring. ULP-G ULP-G was hired on March 21, 2025, to provide direct care services to the facility's residents. On July 9, 2025, at 7:10 p.m., the surveyor called and spoke to ULP-G who was working at the facility. ULP-G stated she and ULP-H were the two ULPs at the facility for the afternoon shift. ULP-G stated she or ULP-H would assist R8 that evening. ULP-G stated she was not trained "to do" TEDs or warm packs/K-pads. ULP-G record lacked evidence of training or competency for TEDs, K-pad or warm pack, or glucose monitoring. On July 8, 2025, at 12:16 p.m., CNS-C stated there was no training or competencies completed for warm packs. The surveyor asked what a "K-Pad" was, and CNS-C stated she thought it was a heating pad? CNS-C confirmed she had not trained on K-paks or warm packs. CNS-C stated the licensee's standing orders needed to be reviewed and updated. CNS-C stated in the past, she (CNS-C) trained and deemed ULPs competent on TEDS when there was a "hiring package" however, with the new system in place she no longer trained/deemed ULPs competent for TEDs. CNS-C stated she did not think about training and deeming competent on TEDs since	01950		

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01950	Continued From page 86 the list was no longer used. CNS-C stated she was not able to find documentation in any of the employee's files including ULP-F's file. CNS-C stated ULP-F had been here the longest. CNS-C stated she had been prepared to train the newest ULP hired on glucose monitoring and had prepared the equipment however that ULP did not show up for the training. CNS-C confirmed ULP were not trained or deemed competent with glucose monitoring. SPECIFIC INSTRUCTIONS On July 8, 2025, at 6:32 a.m., the surveyor observed ULP-D apply TEDs to R8's legs using correct technique. On July 8, 2025, at 8:45 a.m., ULP-D reviewed R8's record. ULP-D stated R8's record did not include what or when to report an issue to nursing regarding R8's TEDs. On July 8, 2025, at 10:11 a.m., R8's record was reviewed with CNS-C. CNS-C stated R8's record included TEDs when she came (started at site). CNS-C stated R8's record should have included what and when to report issues to nursing, such as increased swelling. CNS-C confirmed R8's record lacked required information. CNS-C stated R8 was the only resident who wore TEDs. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy reviewed June 11, 2024, noted: - before performing the procedures, the CNS/RN had instructed the ULP in the proper methods to administer the treatment and therapy and the ULP had demonstrated the ability to competently follow the procedures - the CNS/RN had developed written, specific instruction for each resident	01950		

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01950	Continued From page 87 - the CNS/RN had communicated with the ULP about the individual needs of the resident - the CNS/RN had documented that the ULP had been trained and had demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of three residents (R8) with hospital-style bed rails. Further, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for one of two residents (R3) with an oxygen tank. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	02310		

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02310	Continued From page 88 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This resulted in an immediate correction order on July 8, 2025. Correction order amended on July 9, 2025, to add additional information. The findings include: R8's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), Alzheimer's disease, chronic fatigue, and developmental disability. R8's service plan dated February 23, 2022, indicated R8 received assist with support stockings (TEDs/compression hose), dressing, grooming, incontinence care and bathing assistance. R8's assessment dated June 19, 2025, included: - mobility, bed: needs help to be turned and repositioned: reposition the resident every two hours through the night to prevent skin breakdown. She needs an assistant to get into bed at night and remove her compression stockings - bed safety: the bed safety zone assessment is not applicable, either has no bed rails in use or has portable bed rails that are installed on a consumer bed: there (sic) bedrails attached to resident's bed but are not being utilized. R8's Bed Safety Assessment dated June 19, 2025, noted: - bed type: electric bed	02310		

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02310	Continued From page 89 - mattress type: mattress original to bed, original to bed - no assistive devices needed for bed: has bed rails which are not being used. - the bed safety zone assessment is not applicable, either has no bed rails in use or has portable bed rails that are installed on a consumer bed: there (sic) bedrails attached to resident's bed but are not being utilized. On July 8, 2025, at 6:32 a.m., the surveyor observed an upper half bed rail attached to R8's hospital bed in the lowered position while unlicensed personnel (ULP)-D applied TEDs using correct technique to R8's legs. ULP-D asked R8 to "scoot" legs out, all the way. ULP-D asked R8 to use R8's legs while R8 exited the hospital bed. On July 8, 2025, at 8:27 a.m., ULP-D stated R8 does not currently use the bed rails, but added "I feel like there was a time she (R8) did." On July 8, 2025, at 9:10 a.m., licensed assisted living director/owner (LALD/O)-A stated she was told at the last survey if the bed rails were not in use, an assessment was not needed. LALD/O-A and the surveyor went to R8's room. LALD/O-A was able to lift up the hospital bed rail (the bed rail could be used). LALD/O-A stated she forgot the bed rail was on R8's bed. LALD-B reviewed R8's record with the surveyor and stated R8's record lacked a bed rail assessment. On July 8, 2025, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated she was not aware R8 had a bed rail. CNS-C stated she had never seen R8 use a bed rail. CNS-C added she does bed rail assessment right away, when she is aware of bed rails.	02310		

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02310	Continued From page 90 R8's record lacked a comprehensive assessment on the use of an assistive device and lacked bedrail measurements. Further, R8's record lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative, and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. The licensee's Devices and Device Assessment policy dated March 1, 2024, noted: - due to the risk of injury related to the use of physical devices, such devices would only be used after an assessment had been competed to determine the risks and benefits of this use - the resident/responsible party would be educated regarding the risks and benefits of physical devices. Physical devices would be reviewed for safety and used according to manufacturer's recommendation - contained use of physical device would be assessed at least every 90 days or with significant change to determine if the device was still needed to enhance the resident's safety and/or bed mobility - documentation would be entered in the resident's record to include: - results of the assessment - discussion with resident/responsible party regarding risks and benefits and alternatives considered/ recommended - discussion made/outcome of discussion - for hospital beds, devices would be installed per FDA (Food and Drug Administration) guidelines - physical devices would be assessed for safety during each re-assessment. If there were any safety issues identified, the Licensed Assistant Living Director would be notified immediately.	02310		

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02310	Continued From page 91 The Guidance for Industry and FDA (Federal and Drug Administration) Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, noted, reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment and monitoring, as well as meeting patient, resident, and family needs for vulnerable patients in most health care settings - hospitals, long term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending on the patient, FDA encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. FDA recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories. The FDA "A Guide to Bed Safety" revised April	02310		

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02310	Continued From page 92 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". OXYGEN STORAGE On July 7, 2025, at 12:01 p.m., during a tour of the facility with LALD/O-A the surveyor observed four small oxygen tanks and one medium oxygen tank in a storage rack in R3's room. In addition, LALD/O-A and the surveyor observed one small oxygen tank sitting on R3's floor, near R3's bed, unsecured. LALD/O-A stated that was R3's "portable" oxygen tank that was used when R3 was not near the oxygen concentrator (out of R3's room). LALD/O-A confirmed R3's oxygen tank was unsecured. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to date service plan subject to accepted health care standards.	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 93 No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 7, 2025, at 10:14 a.m., during the entrance conference with licensed assisted living	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	07/10/2025

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BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

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02430	Continued From page 94 director/owner (LALD/O)-A stated clinical nurse supervisor (CNS)-C was at "work and "had to sit through a required meeting." LALD/O-A stated CNS-C was the "head nurse at a clinic in [name of location/city]. LALD/O-A stated there were no additional nurses at the facility and CNS-C could sometimes not answer the phone but CNS-C would answer a text message. LALD/O-A added the texts were sent just to alert CNS-C to a message in the on-line system used. LALD/O-A stated staff (unlicensed personnel/ULP) use their personal cell phones. LALD/O-A stated "we never put names" in text messages. R1's resident notes included: -dated January 18, 2025, attempted to contact resident's sister. Sent a text message that resident was transported to Essentia Heath St. Mary's (name of hospital) for evaluation due to breathing issues, confusion and disorientation. On July 10, 2025, at 9:08 a.m., CNS-C stated she gets text messages if someone (resident) fell, or if a medication was missed, or if a resident was not feeling well. CNS-C stated as far as she knew ULPs used their personal phones to text her (CNS-C). CNS-C stated she kept her phone locked (secured) but CNS-C added she did not know if all ULPs kept their personal cell phones locked (secured). CNS-C stated no secure application was used by the licensee to ensure text messages were kept secure. CNS-C stated it made sense to use only a secured system when text messages were sent. The licensee's Confidentiality of Resident Records and Information and Access to Records policy dated November 15, 2023, noted all staff members are responsible to make sure confidentiality was maintained. Personal financial,	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(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
02430	Continued From page 95 medical, or other information about the resident will not be disclosed to any other person, except: -as may be required by law -to staff who need the information in order to carry out their responsibility -to employees or contractors of our assisted living fancily, another assisted living provider or other health care practitioner or provider, or inpatient facility needing information in order to provide services to the resident, but only such information that was necessary for the provision of services -assess to paper and electronic resident records would be limited to only the information needed by employees, contractors, other health care providers. If access to electronic records cannot be appropriately limited only to the information that is needed to perform the required task, the employees, contractors or other health care providers shall be given hard copies of the information they need to perform their duties. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to have personal, financial, health, and medial information private. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Brooke Manor Inc
4878 Highway 31
Brookston, MN 55711
St. Louis County
Parcel:

Phone: 218-453-5262
gated1@msn.com

License Info

License: HFID 30235□
Virginia Tuominen
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7983251027
Inspection Type: Full - Single
Date: 7/7/2025 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

1) Inspected the well and the subsurface sewage treatment system.

2) A well water sample was collected on 10/09/2024. The results of the water sample analysis were as follows:
TC = absent; E. coli = absent; NO3 = 1.1 mg/L; NO2 = ND; CU = 17.4 ug/L; MN = 7.1 ug/L.

Provided fact sheets re. copper and manganese in drinking water.

A water sample has not yet been submitted for 2025. Water analyses for total coliform bacteria and nitrate nitrogen are required annually.

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

I acknowledge receipt of the Duluth District Office inspection report number F7983251027 from 7/7/2025

Virginia Tuominen
Owner

Gary Collyard,
Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Brooke Manor Inc
Brookston
County/Group: St. Louis County

Inspection Info

Report Number: F7983251027
Inspection Type: Full
Date: 7/7/2025
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: Cut Watermelon**; Temperature Process:** Cold-Holding
Location: Whirlpool Refrigerator/Freezer at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Shell Egg**; Temperature Process:** Cold-Holding
Location: Samsung Refrigerator/Freezer at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: All Foods Frozen Solid**; Temperature Process:** Cold-Holding
Location: Frigidaire Single-Door Upright Freezer at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: All Foods Frozen Solid**; Temperature Process:** Cold-Holding
Location: Left Thomson Chest Freezer at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: All Foods Frozen Solid**; Temperature Process:** Cold-Holding
Location: Right Thomson Chest Freezer at N/A Degrees F.
Comment:
Violation Issued?: No