Electronically Delivered

July 9, 2025

Licensee
Oasis Care Home LLC
514 Britz Drive
Luverne, MN 56156

RE: Project Number(s) SL33288016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33288	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(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: SL33288016-0 On May 12, 2025, through May 15, 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 five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was evaluated twice a year to ensure appropriate staffing levels. 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Direct Care Staffing Plan was completed on May 15, 2024. On May 12, 2025, at 9:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they reviewed the staffing plan annually. LALD/LPN-A stated she was unaware it needed to be completed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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	0 680		

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0 680	Continued From page 3 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 provided a document titled Emergency Action Plan dated June 5, 2024, identified as the facility's emergency preparedness plan. The Emergency Action Plan lacked the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and	0 680		

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0 680	Continued From page 4 how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - facility risk assessment; - arrangements/contracts to re-establish utility services; - all hazards approach with categorized probable risks/hazards by likelihood of occurrence; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - identification of at-risk population needs like maintaining independence, communication, transportation, supervision and medical care; - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program; - policies and procedures based on the EP, risk assessment and communication plan; - policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of	0 680		

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0 680	Continued From page 5 medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement,	0 680		

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0 680	Continued From page 6 and volunteers consistent with their expected roles. - documentation of all EP training; and - emergency prep testing requirements. - Missing Resident Policy dated August 2022, failed to be reviewed quarterly as required. On May 13, 2025, at 2:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all information for emergency preparedness was provided and she was unaware the emergency preparedness plan did not have all the required content. The licensee had not completed a hazard vulnerability assessment and did not have memorandums of understanding developed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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	0 950		

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0 950	Continued From page 7 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 interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for tow of two residents (R2, R3). 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 May 12, 2024, licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided a folder that contained the admission documents. The folder did not contain on a	0 950		

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0 950	Continued From page 8 separate page from the contract the verbatim required statement; "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." R2 R2's Resident Agreement Assisted Living dated January 27, 2025, included a section for R2 to list a designated representative and "If Resident declines to name a Designated Representative, Resident please initial here" with a box to initial. A designated representative was not listed and the box was not checked. R2's record lacked evidence R2 had been provided, on a separate page from the contract the verbatim required statement; "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."	0 950		

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0 950	Continued From page 9 R3 R3's Resident Agreement Assisted Living contract was signed by R3 on August 31, 2022. R3's record lacked evidence R4 had been provided, on a separate page from the contract the verbatim required statement; "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." On May 12, 2025, at 11:44 a.m., LALD/LPN-A stated she was unaware of the designated representative required verbatim statement that was to be provided on a separate page from the contract. LALD/LPN-A stated R2's contract should have had the box checked for declining a designative representative. No further information was provided. TIME PERIOD FOR CORRECTION: 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	01060		

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01060	Continued From page 10 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (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	01060		

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01060	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all the required content to the resident, legal representative, and designated representative, for an emergency relocation for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1's care notes indicated R1 was sent to the emergency room on April 28, 2025, was admitted to the hospital and subsequently admitted to hospice. R1's Notification of Emergency Relocation form dated May 2, 2025, indicated R1 was transferred to the emergency room on April 28, 2025, was admitted to the hospital, and was then transferred to hospice on May 7, 2025. R1's record lacked evidence the Notification of Emergency Relocation form had been provided to the resident and/or the resident's responsible party, or that it had been provided to the ombudsman as required. R2 R2's hospital Plan of Care indicated R2 was hospitalized from March 6, 2025, through March	01060		

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01060	Continued From page 12 8, 2025. R2's record lacked evidence a Notification of Emergency Relocation form had been provided to the resident and/or the resident's responsible party. On May 13, 2025, at 9:50 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated when a resident is sent to the hospital, the facility fills out the Notification of Emergency Relocation form. LALD/LPN-A stated she was unaware the form needed to be provided to the resident and/or the resident's responsible party as soon as practicable and provided to the Ombudsman if the resident is gone from the facility for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 13 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP)-C, ULP-D, ULP-E). This had the potential to affect all residents living in 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on May 18, 2019, under the Comprehensive Home Care license and began providing services under the Assisted Living license on August 1, 2021. On May 12, 2025, at 12:02 p.m., the surveyor observed ULP-C administering medications to residents. ULP-C had a background study completed May 10, 2019, affiliated with health facility identification number (HFID) 33173, which was the	01290		

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01290	Continued From page 14 Comprehensive Home Care HFID. ULP-C's background study was not affiliated with the assisted living facility (ALF) license HFID 33288. ULP-D ULP-D was hired on July 3, 2017, under the Comprehensive Home Care license and began providing services under the Assisted Living license on August 1, 2021. ULP-D had a background study completed July 3, 2017, affiliated with the Comprehensive Home Care HFID 33173. ULP-D's background study was not affiliated with the ALF license 33288. ULP-E ULP-E was hired on April 20, 2018, under the Comprehensive Home Care license and began providing services under the Assisted Living license on August 1, 2021. ULP-E had a background study completed May 5, 2018, affiliated with the Comprehensive Home Care HFID 33173. ULP-e's background study was not affiliated with the ALF license 33288. On May 12, 2025, at 10:42 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the three staff were employed prior to the assisted living conversion and they had background studies completed when they were hired. LALD/LPN-A stated she was unaware they were required to be affiliated to the assisted living HFID. The licensee's Background Checks policy dated July 2024, indicated all staff providing direct care would pass a background study before contact with the residents.	01290		

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01290	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing	01440		

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01440	Continued From page 16 those services for one of one 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: ULP-F was hired on December 4, 2024, to provide direct care services. On May 13, 2025, at 8:06 a.m., the surveyor observed ULP-F assist with completing wound care for R3. ULP-F's New Hire Review signed by licensed assisted living director/licensed practical nurse (LALD/LPN)-A indicated ULP-F was doing a great job and LALD/LPN-A was happy with the activities being done with the residents. ULP-F's employee record lacked evidence a RN conducted direct supervision of delegated nursing tasks within 30 days of first providing those services. On May 13, 2025, at 1:36 p.m., LALD/LPN-A stated the 30-day supervisory visit was the New Hire Review completed by her. LALD/LPN-A stated she was unaware the supervisory visit had to be completed by a RN and the supervision was to be on delegated tasks.	01440		

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01440	Continued From page 17 The licensee's Supervision of Licensed and Unlicensed Personnel policy dated July 2024, indicated 3. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or Assigned Therapy Services. a. A RN will supervise staff who perform delegated nursing, treatment or therapy services. b. Supervision of ULPs by an RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. c. On-going supervision will be completed as needed based upon staff performance. d. This requirement also applies to staff who have not performed delegated tasks for one year or longer. The licensee's Supervision of HHA (home health aide) or ULP dated August 1, 2021, identified HHA's and ULP will be supervised by a Registered Nurse (RN) or delegated to the Licensed Practical Nurse (LPN) during the first 30 days of employment after completion of the HHA class. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 18 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 19 (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-F) received orientation to include the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on December 4, 2024, to provide direct care services. On May 13, 2025, at 8:06 a.m., the surveyor observed ULP-F assist with completing wound care for R3.	01470		

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01470	Continued From page 20 ULP-F's employee file lacked evidence the following required orientation had been completed: - an overview of assisted living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On May 14, 2025, at 1:54 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-F should have had all the required orientation but it had not been assigned. The licensee's Assisted Living Orientation policy dated August 2022, indicated ULPs would have all the required orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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	01530		

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01530	Continued From page 21 de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member 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:	01530		

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01530	Continued From page 22 Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) received the required amount of dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on December 4, 2024, to provide direct care services. On May 13, 2025, at 8:06 a.m., the surveyor observed ULP-F assist with completing wound care for R3. ULP-F's employee file indicated ULP-F had completed five hours of online dementia training. On May 14, 2025, at 1:54 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-F had worked more than 160 hours and should have completed the required eight hours of dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 23	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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 a comprehensive assessment within 14 days of starting services for one of one resident (R2), failed to complete a comprehensive assessment after hospitalization for one of one resident (R2), failed to complete a comprehensive assessment after falls for three of three residents (R2, R1, R3), and failed to complete a comprehensive	01620		

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01620	Continued From page 24 assessment every 90 days as required for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the facility and began receiving services on January 27, 2025. On May 12, 2025, at 12:02 p.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R2. R2's service plan dated January 27, 2025, indicated R2's services included dressing, bathing, and medication administration. R2's record identified the following assessments: - Admission Assessment dated January 27, 2025; and - 14-day assessment dated February 19, 2025, 23 days after R2 began receiving services, thus exceeding 14 days. R2's hospital discharge Plan of Care indicated R2 was hospitalized March 6, 2025, through March 8, 2025, and R2 had medication changes. R2's Care Notes included the following: - February 5, 2025, licensed assisted living	01620		

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01620	Continued From page 25 director/licensed practical nurse (LALD/LPN)-A documented R2 was complaining of pain with sitting, felt as if she needed to have a bowel movement but was unable to pass it, and had been having hard stools. LALD/LPN-A contacted clinical nurse supervisor (CNS)-B by phone and was directed to refer R2 to her primary care physician. - February 8, 2025, ULP-G documented "Hospital report- Client arrived home from hospital at 1:15 pm (3/8). Labs were drawn and INR was high (indicates blood was too thin) so warfarin (blood thinner) is to be held till [sic] follow up with [medical doctor] In 2-3 days. Appointment will need to be scheduled to see [medical doctor]. Anticoag Pharmacy should be calling on Monday, make sure they follow up. Client (resident) was started on Vitamin D 5,000 units once a day, was already given upon arrival. IV was placed in clients (resident's) R (right) forearm with some minor bruising around the area. A cotton ball and Band-Aid were placed over the site. Vitals are stable. Client (resident) has some bruising around the rectum due to stool removal and the area is very tender. Recommended reclining to take pressure off. Client (resident) has occasional incontinent liquid stool due to the removal, keep a pad or pull-up on at all times. Documents from visit have been scanned in." R2's record lacked evidence a comprehensive assessment had been completed by CNS-B upon return from the hospital. R2's Incident Reports included: - March 13, 2025, at 2:15 p.m. ULP-C documented R2 had tripped on her shoes and was on the floor on her right side. R2's head was toward the door and she stated she had hit her head. R2 had skin tears on her right elbow and	01620		

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01620	Continued From page 26 the right side of her face above her eyebrow and under the right eye. ULP-C completed vital signs and contacted LALD/LPN-A. - April 18, 2025, at 6:30 p.m., ULP-H heard a "bump" and found R2 on her bedroom floor. R2 was lying on her left side and holding herself with her arm bent at the elbow. The room was clear of any objects, R2 had one shoe on her left foot and the right shoe was by the nightstand. ULP-H notified LALD/LPN-A and "nurse was informed". R2 told ULP-H that she had hit the top portion of her forehead on the carpeted floor. ULP-H noted a slight red discoloration under her left eye. At 7:30 p.m., LALD/LPN-A documented she had assessed R2 and found no bruising or injuries. LALD/LPN-A explained to R2 she needed to notify staff immediately if she got a headache or had any pain. "RN notified as well" R2's record lacked evidence a RN had reviewed the incident reports, had completed a focused assessment, or had completed a comprehensive assessment after either fall to determine the root cause of the fall and implement changes to prevent further falls. R1 R1 was admitted to the facility and began receiving services on August 5, 2024. R1's care notes indicated R1 was sent to the emergency room on April 28, 2025, was admitted to the hospital and subsequently admitted to hospice. R1's service plan dated October 1, 2024, indicated R2's services included grooming, bathing, behavior management, and medication administration.	01620		

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	33288	A. BUILDING: _____ B. WING _____	05/15/2025

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01620	Continued From page 27 R1's record included the following assessments: - Clinical Update Assessment completed November 6, 2024; and - Clinical Update Assessment completed February 12, 2025, 98 days after the previous assessment, thus exceeding 90 days. R1's incident reports included two separate incidents on April 28, 2025: - On April 28, 2025, at 5:10 a.m., ULP-F heard R1 calling out. ULP-F and another staff went in and found R1 half laying/half sitting on the floor next to the bed. ULP-F checked vital signs and contacted LALD/LPN-A. On April 29, 2025, at 6:27 p.m., LALD/LPN-A documented she had contacted the family on April 28, 2025, at 7:30 a.m., and discussed the fall on Sunday and the two falls early Monday morning and explained R1 needed to be seen due to the number of falls she had in less than 24 hours. Family agreed and transported R1 to the emergency room at 8:45 a.m. On April 30, 2025, at 7:27 p.m., CNS-B reviewed the incident report and although R1 was no longer at the facility, CNS-B documented to prevent falls: "No injuries, staff to keep closer eye on patient, as she is currently being treated for UTI and experiencing increased lethargy." - On April 28, 2025, at 8:00 a.m., ULP-F heard R1 scream for help. ULP-F found R1 sitting on the floor with her back against the wall. R1 had no signs of injury. ULP-F checked vital signs and reported the fall to LALD/LPN-A. On April 29, 2025, at 6:27 p.m., LALD/LPN-A documented she had contacted the family on April 28, 2025 at 7:30 a.m., and discussed the fall on Sunday and the the two falls early Monday morning and explained R1 needed to be seen due to the number of falls she had in less than 24 hours. Family agreed and transported R1 to the emergency room at 8:45 a.m. On April 30, 2025, at 7:29 p.m., although R1	01620		

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01620	Continued From page 28 was no longer at the facility, CNS-B documented interventions to prevent falls: "Staff to monitor patient closely. Make sure walker Is within reach, and give reminders to use walker", and a root cause analysis of "Currently being treated for UTI, and has increased lethargy." R1's record lacked evidence a RN had reviewed the incident reports, had completed a focused assessment, or had completed a comprehensive assessment on R1 after either fall to determine the root cause of the fall and implement changes to prevent further falls. Documentation for both incidents was the same. R3 R3 was admitted to the facility and began receiving services on August 24, 2024. R3's service plan dated August 31, 2022, indicated R3's services included dressing, grooming, bathing, behavior management, and medication administration. R3's recording included the following assessments: - Clinical Update Assessment dated August 17, 2024; - Clinical Update Assessment dated November 27, 2024, 102 days after the previous assessment, thus exceeding 90 days; and - Clinical Update Assessment dated March 1, 2025, 94 days after the previous assessment, thus exceeding 90 days. R3's incident report dated December 26, 2024, at 4:55 p.m., indicated when ULP-D entered the room, R3 was on her bedroom floor. R3 had been attempting to put on her jacket, lost her balance and fell. ULP-D contacted LALD/LPN-A at 5:00	01620		

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01620	Continued From page 29 p.m. and notified her of the fall. R3 complained of left knee and left ear pain. ULP-D noted a skin tear the size of a silver dollar on her kneecap and a bruise on the left cheekbone. ULP-D cleaned the skin tear and applied Steri strips and a dressing. ULP-D documented "Patient lost balance while trying to put on her light jacket, swung jacket up on shoulder and lost her balance" as the root cause analysis and to prevent further falls R3 was instructed to ask staff for assist in putting on her jacket. The incident was not reviewed by CNS-B until December 30, 2024, at 6:33 p.m. R3's record lacked evidence a RN had reviewed the incident reports, had completed a focused assessment, or had completed a comprehensive assessment on R3 after the fall to determine the root cause of the fall and implement changes to prevent further falls. On May 12, 2025, at approximately 9:30 a.m. during the entrance conference, LALD/LPN-A stated CNS-B was the only nurse working for the provider and CNS-B completed all the assessments. CNS-B was onsite Wednesday evenings from approximately 5:00 p.m. to 7:30 p.m., CNS-B was available by phone 24 hours a day. If there was a fall or a hospital return, CNS-B would come in to the facility to complete an assessment if needed. On May 13, 2025, at 9:50 a.m., LALD/LPN-A stated CNS-B wouldn't typically come in after a fall unless it was something serious like the resident hit their head, but would follow up and check on the resident the next time she was at the facility. There were not post fall root cause analysis completed by CNS-B. LALD/LPN-A stated CNS-B typically doesn't fill anything out on	01620		

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01620	Continued From page 30 the incident but she reviewed them. LALD/LPN-A stated R2's assessment (previously identified as the 14-day assessment) dated February 19, 2025, was after the hospitalization and it was completed late. At 2:11 p.m., LALD/LPN-A further stated a nurse should probably complete an assessment upon hospital return as it was a significant change in condition. On May 13, 2025, at 11:44 a.m., ULP-F stated when a resident fell she was trained to call either LALD/LPN-A or ULP-C, whomever was on call. ULP-F stated she had not called CNS-B for any reason, including post falls. The licensee's Initial and On-going Nursing Assessment of Residents policy dated July 2024, identified A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition" 4. On-Going Assessments of Residents. a. The RN will re-assess each resident on an on-going basis. b. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. c. The RN will reassess the resident if the resident has a change in condition d. At these re-assessments, the RN will: i. review the resident's service plan ii. evaluate the resident's medication	01620		

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01620	Continued From page 31 management services and the resident's medications iii. evaluate the resident's treatments, if any iv. communicate any new problems or concerns to the resident's physician or health care providers, and v. update the service plan as necessary based on the resident's needs. e. Re-assessments and ongoing resident monitoring may be conducted at the resident's residence or through the telecommunication methods based on practice standards that meet the resident's needs. The method of reassessment and/or monitoring visits must be disclosed in the service plan. The result of the resident monitoring visits and re-assessments will be documented by the licensed nurse. No further information was provided. 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	01640		

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01640	Continued From page 32 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: Bases on observation, interview, and document review, the licensee failed to ensure service plan modifications were completed and signed when the resident's services changed for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the facility and began receiving services on January 27, 2025. On May 12, 2025, at 12:02 p.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R2. R2's Service Recap Summary dated May 2025,	01640		

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01640	Continued From page 33 included the following services signed off by staff when completed: ambulation/exercise, bathing, dressing, behavior management every shift, medication administration. R2's service plan dated January 27, 2025, indicated R2's services included dressing, bathing, and medication administration. R2 service plan did not include behavior management. R3 R3 was admitted to the facility and began receiving services on August 24, 2024. R3's service plan dated August 31, 2022, indicated R3's services included activity assistance dressing, grooming, bathing, behavior management, and medication administration. R3's Service Recap Summary dated May 2025, included the the following services signed off by staff when completed: ambulation/exercise, bathing, dressing, medication administration. The Service Recap Summary did not include activity assistance or behavior management as identified in the service plan. On May 13, 2025, at 2:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated anytime services change, a new service plan should have been printed and signed. The licensee's undated, Service Plans and Client Records - Development and Revision of the Service Plan policy indicated: If a review of the service plan indicates that the client's (resident) service plan needs modification based on the client's needs, preferences, or changes in fees,	01640		

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01640	Continued From page 34 the RN, therapist and/or other licensed health professional (as applicable) makes necessary changes to the service plan, signs the revised service plan with name, title and date, and requests that the client (resident) and/or the client's (resident) representative sign and date the revised service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 35 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R2	01730		

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01730	Continued From page 36 R2 was admitted to the facility and began receiving services on January 27, 2025. On May 12, 2025, at 12:02 p.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R2. R2's service plan dated January 27, 2025, indicated R2's services included dressing, bathing, and medication administration. R2's Individualized Medication Management Plan dated February 19, 2025, did not include the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R3 R3 was admitted to the facility and began receiving services on August 24, 2024. On May 13, 2025, at 7:10 a.m., the surveyor observed ULP-C administering medications to R3. R3's service plan dated August 31, 2022, indicated R3's services included activity	01730		

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01730	Continued From page 37 assistance dressing, grooming, bathing, behavior management, and medication administration. R3's Individualized Medication Management Plan dated February 19, 2025, did not include the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On May 13, 2025, at 2:16 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the medication management plans should have included all required content. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated July 1, 2024, indicated the RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, p references, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident	01730		

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01730	Continued From page 38 instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications e. Identification of medication management tasks that may be delegated to an unlicensed person. f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription	01890		

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01890	Continued From page 39 label with legible information for two of five residents (R2, R4). 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 May 13, 2025, at 10:40 a.m., the surveyor observed the medication storage drawers with ULP-C and noted the following: - R2 had a open bottle of Debrox ear drops which did not contain a pharmacy label and was not marked with the resident's name; and - R4 had a tube of diclofenac gel that was open and in use and did not contain a pharmacy label. On May 13, 2025, at 2:16 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all medications should have a pharmacy label and if it is over the counter medication, it should be labeled with the residents name. The licensee's Storage of Medications policy dated July 2024, indicated the following: b. 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,	01890		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(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
01890	Continued From page 40 expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. c. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33288	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02240	Continued From page 41 (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide all five residents with the current version of the Minnesota Bill of Rights for Assisted Living. 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:	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33288	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02240	Continued From page 42 During the entrance conference on May 12, 2025, at 9:10 a.m., the surveyor requested the admission information given to residents to include the Bill of Rights. The licensee provided the Combined Federal and State Home Care Bill of Rights for Assisted Living Clients dated October 1, 2022, instead of the current Minnesota Bill of Rights for Assisted Living. On May 12, 2025, at 11:44 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all residents would have received the same Bill of Rights that was provided to the surveyor. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

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

Food & Beverage Inspection Report

Establishment Info

Oasis Care Home LLC
514 Britz Drive
Luverne, MN 56156
Rock County
Parcel:

Phone: 507-449-6156

License Info

License: HFID 33288
Mandy Brecher
Risk:
License:
Expires on:
CFPM: Mandy Marie Brecher
CFPM #: 124397; Exp: 7/31/2027

Inspection Info

Report Number: F7990251003
Inspection Type: Full - Single
Date: 5/13/2025 Time: 11:00:40 AM
Duration: minutes
Announced Inspection:
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

Establishment is using pre-mixed Purell Foodservice Surface Sanitizer. Employee illness log, Temp logs for coolers / freezers, and dishmachine sanitizer logs were all in place.

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

I acknowledge receipt of the Mankato District Office inspection report number F7990251003 from 5/13/2025

Benjamin D. Ische

Mandy Brecher
Owner

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Oasis Care Home LLC
Luverne
County/Group: Rock County

Inspection Info

Report Number: F7990251003
Inspection Type: Full
Date: 5/13/2025
Time: 11:00:40 AM

New Record: **Product/Item/Unit:** Kitchen Reach in Cooler**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 40 Degrees F.
Comment: Shredded Cheese
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7990251003

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 5/13/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00:40 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Oasis Care Home LLC	514 Britz Drive	Luverne, MN	56156	507-449-6156
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 33288	Mandy Brecher	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	IN	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	IN	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Benjamin D. Asche

Follow-up: Follow-up Date: