



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 9, 2025

Licensee

Laurels Edge Assisted Living

77 Stadium Road

Mankato, MN 56001

RE: Project Number(s) SL30675016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30675	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER LAURELS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 77 STADIUM ROAD MANKATO, MN 56001			
(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: SL30675016-0 On August 25, 2025, through August 28, 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 50 residents; 50 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to hand hygiene with glove use and eye drop administration by one of one unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 510			

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0 510	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 On August 26, 2025, at 7:19 a.m., the surveyor observed ULP-C administer topical medications and wound care for R2 in her apartment. Without cleansing hands, ULP-C donned clean gloves and applied capsaicin (topical pain-relieving cream) to R2's bilateral knees as ordered. ULP-C then removed the gloves, donned another pair of clean gloves without washing or sanitizing hands, and then applied triamcinolone (topical steroid cream to relieve inflammation, itching, and redness) to R2's bilateral lower legs as ordered. ULP-C again removed the gloves and without cleansing hands donned another pair of clean gloves and applied R2's bilateral open toe compression stockings, applied dime sized amount of Bacitracin (topical antibiotic ointment) and Telfa (non-stick dressing for wound care) to reddened areas on R2's bilateral feet, and rolled open toe compression stockings back over the feet to hold the Telfa dressing in place. ULP-C then removed her gloves and washed hands in bathroom sink. During interview at this time, ULP-C stated hands should be washed before and after gloves. R1 On August 26, 2025, at 7:54 a.m., the surveyor observed ULP-C prepare and administer R1's medications. Without gloves, ULP-C administered R2's dorzolamide/timolol (eye drop for glaucoma) and brimonidine (eye drop for glaucoma). During interview at this time, ULP-C stated she does not normally wear gloves for eye	0 510			

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0 510	Continued From page 5 drop administration but "probably should". On August 27, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to sanitize or wash hands before and after every glove use. In addition, CNS-B stated staff are trained and should use gloves for eye drop administration. The licensee's Handwashing policy dated November 2019, noted when conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 775			

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0 775	Continued From page 6 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on August 26, 2025, from 9:31 a.m. through 10:33 a.m., with director of maintenance (DM)-E, regional maintenance (RM)-G and maintenance assistant (MA)-H the surveyor observed the following: SMOKE ALARMS The surveyor entered resident room 208 and observed single-station smoke alarms in the bedroom and living room. MA-H tested the alarm in the living room. The alarm was weak sounding and was not connected to the alarm in the bedroom. MA-H stated they did not know the age of the alarms but agreed they looked older, and the alarm sounded weak. During the tour, the surveyor observed newer style alarms mixed with older alarms in several resident rooms. MA-H and RM-G stated that they would start replacing all the older alarms. State Fire Code in Minnesota Rules, chapter 7511 requires that smoke alarms be replaced when they fail to respond to operability tests, or they exceed ten years from the date of manufacture. CARBON MONOXIDE ALARMS The surveyor observed a fuel burning furnace in the second-floor storage room. There was no carbon monoxide detector in the storage room.	0 775			

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0 775	Continued From page 7 DM-E stated they thought the only carbon monoxide detector in the building was in the boiler room. State Fire Code in Minnesota Rules, chapter 7511 requires either, rooms that contain a fuel burning appliance be equipped with a carbon monoxide detection system, or carbon monoxide alarms be located within ten feet of every sleeping room. LOCKED EXIT The surveyor observed an exit sign above an exterior door in the memory care living room area. The door was locked and required a code to unlock. There was no switch to deactivate the lock. The door led to a fenced courtyard that had a gate locked with a padlock, preventing access to a public way. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. Locked exits must unlock with activation of the fire alarm system and be capable of being deactivated at an approved location. DRYER DUCTS The surveyor observed flexible dryer ducts in all the laundry rooms. There were sharp bends and sags in the ducts, and the ducts doubled over on themselves before connecting to the discharge duct in the wall. Dryer ducts must be installed according to the manufacturers listing. Dryer ducts must be installed without sharp bends and sags that could accumulate lint inside	0 775			

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0 775	Continued From page 8 the duct, creating a fire hazard. DM-E stated they would remove the excess duct and reinstall it. DM-E, RM-G and MA-H verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01440 SS=D	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	01440			

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01440	Continued From page 9 by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-J). 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-J was hired on November 2, 2023, to provide direct care services to residents at the assisted living. ULP-J's employee record contained competencies in medication administration dated May 20, 2025, and a 30-day supervisory form dated May 20, 2025, that included competency in handwashing. ULP-J's employee record lacked documentation of a RN supervising ULP-J performing delegated tasks within 30 days of beginning work with the licensee. On August 28, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated ULP-J had been doing delegated tasks since May 20, 2025, and lacked the required 30-day supervision of delegated tasks as required. The licensee's Supervision of ULP policy dated	01440			

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01440	Continued From page 10 December 2019, noted ULP must be supervised by a registered nurse within 30 days after the date on which the individual begins working for the provider and first performs delegated tasks for clients and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01540			

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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
01540	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-F and ULP-J) received the required amount of dementia, mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an Assisted Living Facility with Dementia Care license. During the entrance conference on August 25, 2025, at 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were aware of the contents of the employee record. ULP-F ULP-F was hired on February 18, 2025, to provide direct care and services to the licensee's residents. ULP-F's employee record contained evidence the employee received 7.25 hours of dementia care training, not the required eight hours of training	01540			

Minnesota Department of Health

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01540	Continued From page 12 within 80 working hours of the employment start date. ULP-F's employee record lacked evidence of completing any mental illness, and de-escalation training. ULP-J ULP-J was hired on November 2, 2023, to provide direct care and services to the licensee's residents. ULP-J's employee record lacked evidence of completed training in mental illness or de-escalation by July 1, 2025. On August 28, 2025, at 1:43 p.m., clinical nurse supervisor (CNS)-B stated the required training had not been completed by ULP-F yet. CNS-B indicated the licensee had transitioned training programs, and in doing so, some individuals have been found not to have the appropriate coursework completed. In addition, CNS-B stated they were working on assigning the mental illness and de-escalation training to all staff indicating none of the licensee's current staff had the required training. The licensee's undated Training Requirement for Assisted Living with Dementia Care policy indicated all staff were required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			

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01750	Continued From page 13	01750			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions for one of one resident (R1) with eye drop administration delegated to unlicensed personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia and glaucoma.	01750			

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01750	Continued From page 14 R1's Assisted Living Agreement Addendum (identified as the service plan) dated May 30, 2025, indicated R1 received services including medication administration. R1's Medication Administration Record (MAR) dated August 2025, included the following: - dorzol/timol (eye drop for glaucoma) 2-0.5% instill 1 drop into both eyes twice daily. - brimonidine (eye drop for glaucoma) 0.2% instill 1 drop into right eye twice daily. On August 26, 2025, at 7:54 a.m., the surveyor observed ULP-C prepare R1's medications. Without gloves, ULP-C administered one drop of the dorzolamide/timolol to both of R2's eyes. ULP-C then placed the cap back on the eye drop bottle, obtained the brimonidine eye drop and immediately administered one drop of the brimonidine eye drop to R2's right eye. During interview at this time, ULP-C stated she did not need to wait between the eye drop administration because the directions did not indicate that. On August 27, 2025, at 2:08 p.m., clinical nurse supervisor (CNS)-B stated staff are taught to wait 5 minutes between eye drops. CNS-B further stated specific instructions should be specified and documented in the resident record for staff to follow. The licensee's Eye Drops and Eye Ointment policy dated November 2019, noted: If more than one kind of eye drop is being used, wait at least 1-2 minutes before using each type. Cosopt (brand name for dorzolamide/timolol) manufacturer's instructions dated October 2009,	01750			

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01750	Continued From page 15 included: If you use other topically applied ophthalmic medications, they should be administered at least 10 minutes before or after dorzolamide hydrochloride-timolol maleate ophthalmic solution. Alphagan P (brand name for brimonidine) manufacturer's instructions dated 2005, included: If more than one topical ophthalmic product is being used, the products should be administered at least 5 minutes apart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for two of four residents (R5, R6) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890			

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01890	Continued From page 16 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 R5's diagnoses included diabetes. R5's Assisted Living Agreement Addendum (identified as the service plan) effective April 11, 2024, included medication administration. R5's prescriber orders dated August 7, 2025, included: - NovoLog FlexPen (fast-acting insulin) 100 units/milliliter 0-14 units as needed with meals for blood sugar reading of: 140-179: administer 2 units 180-219: administer 4 units 220-259: administer 6 units 260-299: administer 8 units 300-339: administer 10 units 340-379: administer 12 units 380-399: administer 14 units 400+: call on call nurse to contact provider. Lispro can also be used, it too is a fast-acting insulin. Give 15 minutes before eating. R5's medication administration record (MAR) dated August 2025, included the medication as ordered above. On August 26, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D administer NovoLog FlexPen to R5. The NovoLog FlexPen had a label that directed to	01890			

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01890	Continued From page 17 administer 6 units before meals with sliding scale 0-14 units every day. When interviewed at this time, ULP-D stated the label for R5's NovoLog FlexPen did not match the MAR or indicate the order had changed, but said she would follow the MAR instead of the label. R6 R6 diagnoses included keratoconjunctivitis sicca (dry eye syndrome). R6's Assisted Living Agreement Addendum effective May 27, 2025, included medication administration. R6's prescriber orders dated July 23, 2025, included: - refresh optive PF (eye lubricant) 0.5-0.9% 1 drop both eyes three times daily. R6's MAR dated August 2025, included the medication as ordered above. On August 26, 2025, at 1:45 p.m., the surveyor observed ULP-F administer refresh optive eye drops to R6. The refresh optive eye drops had a label that directed to administer 2-4 times per day PRN (as needed). When interviewed at this time, ULP-F stated the label for R6's refresh optive eye drops did not match the MAR. ULP-F indicated there should be a sticker on the label from the nurse if the order had changed. On August 27, 2025, at 2:36 p.m., clinical nurse supervisor (CNS)-B stated there should have been a direction change sticker applied to the prescription labels to alert staff of different orders. CNS-B further stated the prescription labels should match the current prescriber orders and	01890			

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01890	Continued From page 18 MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, 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 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).	01960			

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01960	Continued From page 19 The findings include: R2's diagnoses included dementia and venous insufficiency (pooling of blood in the legs). R2's Assisted Living Agreement Addendum (identified as the service plan) dated May 30, 2025, indicated R2 received assistance with medication administration and wound care. R2's signed prescriber orders dated August 6, 2025, included: - ACE (all cotton elastic) bandage; wrap right leg daily on in a.m. off in p.m. - Kerlix (woven gauze dressing) bandage roll; use to wrap right leg wound daily; - triamcinolone acetonide (topical steroid cream to relieve inflammation, itching, and redness)0.025% apply a moderate amount to both legs daily. R2's Service Received documentation dated August 19, 2025, through August 25, 2025, included staff initials (indicating completion of task) for wound care and compression dressing. Instructions included: Remove old dressing, use caution if drainage has attached dressing to skin, wet dressing and remove slowly; apply lotion to red portion of leg. Do not put lotion on wound bed. Place Telfa (non-stick dressing) over wound. Wrap reddened area of leg with Kerlix; apply Tubigrip (compression bandage to reduce swelling) from toes to below knee. Alert nurse to any pink/red skin blister, odor, drainage, abnormal skin, or open areas. R2's Medication Administration Record (MAR) dated August 2025, included staff initials for	01960			

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01960	Continued From page 20 documentation of Kerlix- to wrap leg once daily, and check compression sock- check that compression socks are up to knee and down to toes. Replace if not. On August 26, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-C administer topical medications and wound care for R2 in her apartment. ULP-C applied triamcinolone acetonide cream to R2's bilateral lower legs, applied R2's bilateral open toed compression stockings, applied dime sized amount of Bacitracin (topical antibiotic ointment) and Telfa to reddened areas on both R2's feet, and rolled open toe compression stockings back over the feet to hold the Telfa dressing in place. ULP-C did not use Telfa or Kerlix to wrap leg as directed. ULP-C then removed her gloves and washed hands in bathroom sink. During interview at this time, ULP-C stated they do not put Telfa or wrap R2's right leg with Kerlix anymore. ULP-C stated she was not sure why it is still listed as a task because the area was no longer open or weeping but documents as administered. ULP-C further stated she put Bacitracin and Telfa on both R2's feet because there was redness on both feet not just the right foot as directed, and the nurse had told her she could do that. ULP-C stated she only documented Bacitracin to the right foot. On August 28, 2025, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated staff should follow the MAR instructions for all treatments and alert the nurse if something needs to be changed. CNS-B indicated staff should not document treatments that are not being done. The licensee's Medication and Treatment Orders	01960			

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01960	Continued From page 21 policy dated August 2021, indicated the registered nurse was responsible for assuring that current prescriber orders for medications or treatments administered by staff are kept on file in the clients' records. The licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with client change of condition. A client's MAR and TAR (treatment administration record) would be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by unlicensed personnel (ULP)-C for one of one resident (R2) whose medications were not administered as directed. This practice resulted in a level two violation (a	02320			

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02320	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 25, 2025, at 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents. R2's diagnoses included dementia. R2's Assisted Living Agreement Addendum (identified as the service plan) dated May 30, 2025, included medication administration. R2's RN (registered nurse) Assessment dated June 2, 2025, included the resident had preferences in how to take medications including pills whole with water and potassium to be dissolved in water and drink. R2's prescriber orders dated August 6, 2025, included potassium chloride (supplement) 20 milliequivalents (mEq) once daily. R2's August 2025, Medication Administration Record (MAR) indicated R2 was scheduled and received potassium chloride 20 mEq once daily. The MAR further directed to dissolve the potassium chloride in 120 milliliters (ml) of water and allow to dissolve for 2 minutes. Stir for 30	02320			

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02320	Continued From page 23 seconds, swirl and drink immediately. Add 2 tablespoonfuls of water to the cup, swirl and consume immediately, repeat for final time. On August 26, 2025, at 7:40 a.m., the surveyor observed ULP-C prepare R2's medications. ULP-C broke the potassium chloride pill in half, placed all medications into a medication cup, and administered the medications to R2. ULP-C did not dissolve the potassium chloride in water as directed. When interviewed at this time, ULP-C stated she broke the potassium chloride pill in half because it was "too big for her to swallow". ULP-C further stated the MAR directed to dissolve the potassium chloride in water and indicated she had not followed the directions. On August 27, 2025, at 2:26 p.m., CNS-B stated staff should be following the directions on the resident's medication record and R2's record directed to dissolve the potassium chloride in water. The licensee's Medication Administration by Unlicensed Personnel policy dated revised August 2021, noted specific instructions for the unlicensed personnel on performing the task are written on the assignment sheet/service schedule. The policy further indicated the ULP would review the medication service schedule/MAR for any instructions for the resident for administration and would assemble medications and necessary supplies along with written instruction outlined on the service schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02320			

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02320	Continued From page 24 days	02320			



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

Food & Beverage Inspection Report

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Establishment Info

LAURELS EDGE ASSISTED LIVING
77 Stadium Road
Mankato, MN 56001
Blue Earth County
Parcel:

Phone:
htruebenbach@monarchmn.com

License Info

License: HFID 30675
Audra Johnson
Risk:
License:
Expires on:
CFPM: Jeffrey Hecksel
CFPM #: 18380; Exp: 01/04/2027

Inspection Info

Report Number: F1028251075
Inspection Type: Full - Single
Date: 8/28/2025 Time: 12:27:07 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 6
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: **Once Audra Johnson has received her Certified Food Protection Manager certificate from the State of Minnesota, that certificate must be posted within the establishment.**

Comply By: Comply On Condition Originally Issued On: 8/28/2025

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: **The handwashing sink in the front service area does not meet commercial equipment codes. This sink must be replaced with a sink that meets ANSI standards.**

Comply By: 9/30/2025 Originally Issued On: 8/28/2025

New Order: 4-200 Equipment Design and Construction

4-202.16 Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

COMMENT: **The damaged countertops in the front service area of the kitchen must be removed as they are no longer durable, smooth, or easily cleanable. These countertops must be replaced with non-absorbent countertops that are durable, smooth, and easily cleanable.**

Comply By: 9/30/2025 Originally Issued On: 8/28/2025

New Order: 5-500 Refuse and Recyclables

5-501.16C Priority Level: Priority 3 CFP#: 54

MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.

COMMENT: **Provide a trash bin at the handwashing sink in the front service area.**

Comply By: 9/3/2025 Originally Issued On: 8/28/2025

New Order: 6-100 Physical Facility Construction Materials

6-101.11A1 Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

COMMENT: **The 'popcorn' ceiling in the front service area of the kitchen must be replaced with a smooth, durable, and easily cleanable surface.**

Comply By: 12/31/2025 Originally Issued On: 8/28/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-304.11C *Priority Level: Priority 3 CFP#: 56*

MN Rule 4626.1475C Operate the ventilation system when ventilated equipment is in use.

COMMENT: The switch to turn on the ventilation hood above the cooking equipment is currently located outside.

The previous switch was located within the kitchen but is no longer functional. The inside switch must be repaired as soon as possible to allow for kitchen service staff to be able to turn on the ventilation hood without having to go outside.

Comply By: 8/28/2025 Originally Issued On: 8/28/2025

Food & Beverage General Comment

This Inspection was conducted in conjunction with the Health Regulation Division.

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 F1028251075 from 8/28/2025

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