Electronically Delivered

February 17, 2026

Licensee
Ecumen Worthington The Meadows
1801 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL20011016

Dear Licensee:

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

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20011	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(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: SL20011016-0 On December 8, 2025, through December 11, 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 107 residents; 67 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		

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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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 December 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff 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 complete a hazard/risk vulnerability assessment and failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to	0 680		

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0 680	Continued From page 4 affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's Emergency Operations Program and Plan Manual dated January 2024, indicated "This EOP has been reviewed and approved by our organization's leadership" on August 8, 2022. The emergency plan failed to include: - was not reviewed annually as required; - a hazard risk vulnerability assessment identifying various probable risks/hazards by likelihood of occurrence that is facility and community based; and - Missing Resident policy was dated August 1, 2021, and was not reviewed quarterly as required. On December 11, 2025, at 10:45 a.m., licensed assisted living director (LALD)-A stated they could not find a hazard/risk vulnerability assessment, the emergency plan had not been reviewed annually, and LALD-A stated being unaware the missing person plan had to be reviewed quarterly. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12/12/2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal	0 970		

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0 970	Continued From page 6 property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living did not require residents to waive liability for health, safety, or personal property for two of two residents (R5, R13). 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: R5 R5's record included an untitled document signed by R5 on September 19, 2022, which included the following statements: - "Please review the following "DISCLAIMER, WAIVER, AND RELEASE OF LIABILITY" carefully." - "7.I expressly agree, on behalf of myself, my heirs, executors, administrators, successors and assigns, that the Community and its insurers, employees, officers, directors, parent corporations, subsidiaries, and associates, shall not be liable for any damages arising from	0 970		

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0 970	Continued From page 7 personal injuries (including death) sustained by me as a result of participating in exercise or the use of the equipment, regardless of whether such injuries result, in whole or in part, from the negligence of the Community, its employees, or agents; and - 8. I agree to release, discharge, indemnify, and hold harmless Community and its officers, directors, shareholders, members, employees, agents, parent corporations, subsidiaries, and their respective successors and assigns against any loss, liability, damage, claim, cause of action, known or unknown cost, or expense of any nature whatsoever, arising from my participation in exercise classes or use or operation of the equipment." - "1 (community disclaimer, waiver, release of liability for exercise equipment and classes) I HAVE READ THE FOREGOING DISCLAIMER, WAIVER AND RELEASE OF LIABILITY AND VOLUNTARILY EXECUTED THIS DOCUMENT WITH FULL KNOWLEDGE OF ITS CONTENT." R13 R13's record included an untitled document signed by R13's power of attorney (POA) on September 25, 2025, which included the following statements: - "Please review the following "DISCLAIMER, WAIVER, AND RELEASE OF LIABILITY" carefully." - "7.I expressly agree, on behalf of myself, my heirs, executors, administrators, successors and assigns, that the Community and its insurers, employees, officers, directors, parent corporations, subsidiaries, and associates, shall not be liable for any damages arising from personal injuries (including death) sustained by me as a result of participating in exercise or the use of the equipment, regardless of whether such	0 970		

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0 970	Continued From page 8 injuries result, in whole or in part, from the negligence of the Community, its employees, or agents; and - 8. I agree to release, discharge, indemnify, and hold harmless Community and its officers, directors, shareholders, members, employees, agents, parent corporations, subsidiaries, and their respective successors and assigns against any loss, liability, damage, claim, cause of action, known or unknown cost, or expense of any nature whatsoever, arising from my participation in exercise classes or use or operation of the equipment." - "1 (community disclaimer, waiver, release of liability for exercise equipment and classes) I HAVE READ THE FOREGOING DISCLAIMER, WAIVER AND RELEASE OF LIABILITY AND VOLUNTARILY EXECUTED THIS DOCUMENT WITH FULL KNOWLEDGE OF ITS CONTENT." On December 9, 2025, at 3:30 p.m., licensed assisted living director (LALD)-A stated she was unaware the facility could not waive liability for use of exercise equipment and further stated all residents used the same document. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01440		

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01440	Continued From page 9 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 those services for two of two unlicensed personnel (ULP-C, 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:	01440		

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01440	Continued From page 10 ULP-C ULP-C was hired on November 19, 2024, to provide direct care services to residents. On December 8, 2025, at 11:08 a.m., the surveyor observed ULP-C administering medications to R2. ULP-C's AL New Hire RA Competency Skills Checklist - V6 - Evaluator Review dated December 20, 2024, included all competency testing completed by clinical nurse supervisor (CNS)-B. After all the competency documentation was the following statement "I attest that I, [CNS-B], have ranked and recorded competency review scores and comments for [ULP-C] for the AL New Hire RA Competency Skills Checklist - V6 on 12/30/2024 to the best of my ability. This also serves as the 30-day supervisory visit with the RN." ULP-C's record lacked evidence a supervisory visit for delegated tasks had been completed by a RN, within 30 days after the date ULP-C first performed the delegated tasks for residents. ULP-F ULP-F was hired on August 11, 2025, to provide direct care services to residents. On December 9, 2025, at 8:38 a.m., the surveyor observed ULP-F administering medications to R4. ULP-F's AL New Hire RA Competency Skills Checklist - V6 - Evaluator Review dated October 2, 2025, included all competency testing completed by clinical nurse supervisor (CNS)-B. After all the competency documentation was the	01440		

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01440	Continued From page 11 following statement "I attest that I, registered nurse (RN)-J, have ranked and recorded competency review scores and comments for ULP-F for the AL New Hire RA Competency Skills Checklist - V6 on 10/2/2025 to the best of my ability. This also serves as the 30-day supervisory visit with the RN." ULP-F's record lacked evidence a supervisory visit for delegated tasks had been completed by a RN, within 30 days after the date ULP-F first performed the delegated tasks for residents. An email sent from CNS-C on December 11, 2025, at 10:45 a.m., contained "these supervisory check-offs are completed after on-the-floor training and Relias training is completed. Staff are here at least 30 days prior to these check-offs and being sent off on their own." On December 11, 2025, at 10:54 a.m., CNS-B stated staff are with another unlicensed staff who are a coach or trainer for the first month to six weeks until they feel comfortable to test out on everything. When the staff is ready, the skills packet is completed. The skills and 30 day supervision were the same document. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.	01610		

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01610	Continued From page 12 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial nursing assessment one of three residents (R13) prior to, or on the date of admission. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 8, 2025, at 11:27 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medication to R13.	01610		

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01610	Continued From page 13 R13 began receiving assisted living services on September 29, 2025. R13's service plan signed October 24, 2025, indicated R13's services included bathing, blood glucose supervision, and medication administration. R13's AL Nursing Assessment was signed as completed by clinical nurse supervisor (CNS)-B on October 1, 2025. This was two days after R13 was admitted. On December 10, 2025, at 1:40 p.m., CNS-B stated she is unsure why R13's assessment was signed off two days after admission, other than it may have been from training a new nurse. "Timely assessments had been a problem" and that is why they hired another nurse. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated "A Registered Nurse will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.	01620		

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01620	Continued From page 14 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident	01620		

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01620	Continued From page 15 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 at least every 90 days as required for two of three residents (R5, R6) and failed to complete a wound assessment on a routine basis for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R5 R5 was admitted on July 7, 2015, and began receiving assisted living services August 1, 2021. On December 8, 2025, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R5. R5's service plan signed September 19, 2025, indicated R5's services included soft foods with	01620		

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01620	Continued From page 16 nectar thickened liquids, bathing, dressing, grooming, transfers, ambulation, medication management and administration. R5's record included the following assessments: - AL (assisted living) Nursing Assessment dated April 23, 2025; and - AL Nursing Assessment dated July 31, 2025, this was 99 days between assessments, thus exceeding 90 calendar days. R6 R6 was admitted on March 22, 2018, and began receiving assisted living services on August 1, 2021. On December 9, 2025, at 7:40 a.m., the surveyor observed ULP-C administering medications to R6. R6's service plan signed January 11, 2025, indicated R6's services included pureed diet, assistance with wheelchair mobility, bathing, dressing, grooming, skin care, medication management and administration. R6's record included the following assessments: - AL Nursing Assessment signed March 20, 2025; - AL Nursing Assessment signed June 24, 2025, this was 96 days between assessments; and - AL Nursing Assessment signed September 29, 2025, this was 93 days between assessments, thus both assessments exceeding 90 calendar days. On December 9, 2025, at 8:55 a.m., the surveyor observed ULP-C changing a bandage on R6's right temple. ULP-C removed a large bandage from R6's temple, The surveyor observed a large open wound with drainage. ULP-C cleaned the	01620		

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01620	Continued From page 17 area with a saline rinse, dabbed dry and then placed a clean large bandage on the area. R6's hospice Plan of Care Update dated December 8, 2025, included R6 had an wound to the left forehead which the family stated was possibly cancerous. Skilled nurse to instruct caregiver procedure for wound care. Staff were instructed to cleanse area with soap and water daily. Leave open to air. If R6 was picking at the area, they were to apply a bandage as needed. The hospice note included a goal of caregiver will demonstrate wound care and improved wound status by decreasing is size and drainage and no signs of infection. Instructions related to decubitus ulcer care. Right forehead and nose lesions. Staff were to cleanse the area daily with soap and water and allow to air dry. Leave open to air and may apply bandage to site when drainage is present. Hospice nurse would monitor weekly. R6's September 29, 2024, AL Nursing Assessment indicated R6 had wound care and wound care coordination with hospice. The assessment lacked a comprehensive assessment of the wound. On December 9, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-B stated sometimes the assessments were late and they should have been completed every 90 days. On December 9, 2025, at 2:35 p.m., CNS-B stated the licensee had hospice notes and orders for wound care but the licensee had not completed any wound assessments. CNS-B stated she was unaware the licensee need to complete assessments of the wound since hospice was doing them. CNS-B stated the	01620		

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01620	Continued From page 18 wound has worsened; initially it was smaller and dry, but it had grown and now weeps, so they place a bandage over it. The licensee's Initial and On-Going Nursing Assessment of Residents dated August 1, 2021, indicated the following: "1. A Registered Nurse 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 2. A Registered Nurse will complete assessments as indicated by individual resident circumstances" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 19 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for four of five residents (R5, R6, R12, R13) and failed to ensure a service plan was developed and signed within 14 days for one of one resident (R13). 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: R5 R5 was admitted on July 7, 2015, and began receiving assisted living services August 1, 2021. On December 8, 2025, at 12:07 p.m., the	01640		

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01640	Continued From page 20 surveyor observed unlicensed personnel (ULP)-E administering medications to R5. R5's service plan was signed September 19, 2025. R5's current unsigned service plan printed on December 9, 2025, indicated the following changes had been made after September 19, 2025, when the service plan was last signed: - September 29, 2025, services for occasional reassurance and redirection every shift was added- "Community staff report residents concerns. Community staff provide reassurance and orientation to support resident in the current environment. Community staff provide validation. Community staff repeat information frequently for understanding. Safe care plan in place to meet resident care needs and minimize confusion and paranoia, and to maintain safety." R6 R6 was admitted on March 22, 2018, and began receiving assisted living services on August 1, 2021. On December 9, 2025, at 8:55 a.m., the surveyor observed ULP-C changing a bandage on R6's right temple. ULP-C removed a large bandage from R6's temple, The surveyor observed a large open wound with drainage. ULP-C cleaned the area with saline rinse, dabbed dry and then placed a clean large bandage on the area. R6's Service Plan was signed January 11, 2024. R6's current unsigned Service plan printed on December 8, 2025, indicated the following changes had been made after January 11, 2024, when the Service Plan was last signed:	01640		

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01640	Continued From page 21 - October 22, 2024, a repositioning schedule was added for each shift at specific times. - January 31, 2025, added wound care - Check dressing on right side of forehead, daily. Wash hands and apply gloves. Remove soiled dressing. Wash area on right temple with wound wash, allow to air dry. Cover with large band aide. Hospice will provide .. Wound care performed .. Community to provide assistance with wound care .. Notify nursing if area on temple has increased drainage, pain or redness. - June 24, 2025, service of Wound Observation was added - Observe wounds on resident's temple, and on top of head. Report to nursing any increased pain with wound care. additional swelling, drainage, or foul smelling odor.. Wound care provided by outside agency. Nurse to observe wound for signs of infection, dressing integrity, and pain .. Community to provide assistance with wound care. - June 24, 2025, service of wound care was added - Coordinate with Moments Hospice in wound care and dressings. Wound care will be maintained by the home health hospice, or other nursing agency. Community to provide assistance with maintaining wound integrity." R12 R12 was admitted on February 27, 2023, and received assisted living services. On December 10, 2025, at 9:10 a.m., the surveyor interviewed R12. R12 stated initially she had received assistance with medications and bathing but she stopped having them assist with bathing as she was able to do it independently. R12's Service Plan was signed May 24, 2023. R12's current unsigned Service plan printed on	01640		

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01640	Continued From page 22 December 10, 2025, indicated the following changes had been made after May 24, 2023, when the Service Plan was last signed: - bathing assistance was no longer listed as a service. This also indicated R12's rate for services had decreased. R13 R13 was admitted on September 29, 2025, and received assisted living services. On December 8, 2025, at 11:27 a.m., the surveyor observed ULP-D administering medications to R13. R13's Service Plan was signed October 20, 2025, which was 21 days after the start of R13's services. R13's had a change in services and another service plan was signed on October 31, 2025. R13's Service Plan printed on December 9, 2025, indicated the following changes had been made after October 31, 2025, when R13's last Service Plan was signed: - R13 no longer received bathing assistance. This also indicated R13's rate for services had decreased. On December 10, 2025, at 11:19 a.m., clinical nurse supervisor (CNS)-B stated a service plan should be signed within 14 days of starting services and an updated service plan should be signed when changes in services occur. CNS-B further stated sometimes the licensee would send new service plans to the families, and they didn't sign and send them back.	01640		

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01640	Continued From page 23 The licensee's Content of Service Plans dated August 1, 2021, identified "All assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medications were secured and locked in substantially constructed compartments and permitted only authorized personnel to have access in the memory care medication cabinet (MDC)-C. This had the potential to affect all residents, visitors, and staff in the memory care unit. 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	01880		

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01880	Continued From page 24 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 December 8, 2025, during continuous observation with unlicensed personnel (ULP)-E, the following was observed: - 12:07 p.m. ULP-E set-up R5's medication for administration. ULP-E set the medication cabinet keys on the counter in the dining room with multiple residents and staff remaining in the room, assisted R5 to her room and administered her medications. - 12:12 p.m. ULP-E returned to the dining room and the medication cabinet keys had been removed from the counter. ULP-E opened an unlocked drawer at counter top level and removed the keys, set up medication for R10, placed the keys back in the drawer, and administered R10's medication in the dining room. - 12:21 p.m. ULP-E removed the keys from the drawer, did a review of the medication cabinet with the surveyor and returned the keys to the drawer. ULP-E washed her hands and left the dining area. On December 8, 2025, at approximately 3:00 p.m., clinical nurse supervisor (CNS)-B stated staff should always keep the keys on them and pass from staff to staff at shift change. The licensee's Storage of Medications policy dated August 1, 2021, identified "When secured storage of the medications is necessary, the RN will identify in the resident's individualized medication management plan where the medications will be stored, how they will be	01880		

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01880	Continued From page 25 secured or locked under proper temperature controls and who has access to the medications." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with open and/or expiration dates and failed to ensure all medications were labeled with a pharmacy label in two of two medication carts (medication cart (MC)-A, MC-B) and one of one medication cabinet (MDC-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 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).	01890		

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	20011	A. BUILDING: _____ B. WING _____	12/11/2025

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01890	Continued From page 26 The findings include: MC-A On December 8, 2025, at 11:08 a.m., the surveyor observed MC-A with unlicensed personnel (ULP)-C. The following was observed: - R3's ventolin inhaler did not have a pharmacy label. A handwritten note on the inhaler was R3's first name and initial of last name. In addition, the inhaler was not marked with an open date; - R4's ventolin inhaler was not marked with an open date. MC-B On December 8, 2025, at 11:27 a.m., the surveyor observed MC-B with ULP-D. The following was observed: - R8's albuterol inhaler was not marked with an open date; and - R7's Stiolto Respimat was not marked with an open date. MDC-C On December 8, 2025, at 12:21 p.m., the surveyor observed MDC-C with ULP-E. The following was observed: - R9 had three basaglar insulin pens open and in use with insulin remaining in each of them. Two of the pens did not have a pharmacy label, but they included open dates of November 19, 2025, and November 27, 2025. One pen had a small pharmacy label that did not include instructions for use with an open date of November 30, 2025; - R10's Budesonide/formoterol inhaler did not have an open date; and R10's Lantus insulin had a small pharmacy label which did not include instructions for use. On December 8, 2025, at approximately 3:00 p.m., clinical nurse supervisor (CNS)-B stated	01890		

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01890	Continued From page 27 she was unaware the inhalers had to be labeled with open dates. R3's inhaler should have had a box with it which would include the pharmacy label. The label for insulin pens was on the box in the refrigerator. The licensee's Storage of Medications policy dated August 1, 2021, identified the following: - "Medications will be handled and stored per acceptable standards." - "Until the medication is set up for immediate administration, a legend (prescription) drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications." Ventolin (albuterol) inhaler's prescribing information dated December 2014, included "The inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever comes first." Stiolto Respimat's undated prescribing information included: "Three months after insertion of cartridge, throw away the STIOLTO RESPIMAT even if it has not been used, or when the inhaler is locked, or when it expires, whichever comes first." Budesonide/formoterol prescribing information dated June 2010 included "The inhaler should be discarded when the labeled number of inhalations have been used or within 3 months after removal from the foil pouch."	01890		

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01890	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of three resident (R6) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R6 was admitted on March 22, 2018, and began receiving assisted living services on August 1, 2021. On December 9, 2025, at 8:55 a.m., the surveyor observed ULP-C changing a bandage on R6's right temple. ULP-C removed a large bandage from R6's temple, The surveyor observed a large open wound with drainage. ULP-C cleaned the area with saline rinse, dabbed dry and then placed a clean large bandage on the area. R6's service plan signed January 11, 2025, indicated R6's services included pureed diet, assistance with wheelchair mobility, bathing, dressing, grooming, skin care, medication management and administration. R6's Service plan did not include wound care.	01940		

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01940	Continued From page 30 R6's hospice Plan of Care Update dated December 8, 2025, included R6 had an wound to the left forehead which the family stated was possibly cancerous. Skilled nurse to instruct caregiver procedure for wound care. Staff were instructed to cleanse area with soap and water daily. Leave open to air. If R6 was picking at the area they were to apply a bandage as needed. The hospice not included a goal of caregiver will demonstrate wound care and improved wound status by decreasing is size and drainage and no signs of infection. Instructions related to decubitus ulcer care. Right forehead and nose lesions. Staff were to cleanse the area daily with soap and water and allow to air dry. Leave open to air and may apply bandage to site when drainage is present. Hospice nurse would monitor weekly. R6's Service Checkoff List dated December 1-8, 2025, included the following - Wound care - Check dressing on right side of forehead, daily. Wash hands and apply gloves. Remove soiled dressing. Wash area on right temple with wound wash, allow to air dry. Cover with large band aide. Hospice will provide. Wound care performed. - Wound observation:Observe wounds on resident's temple, and on top of head. Report to nursing any increased pain with wound care, additional swelling, drainage, or foul smelling odor. Wound care provided by outside agency. Nurse to observe wound for signs of infection, dressing integrity, and pain. The wound care and wound observation were signed off once a day by the unlicensed staff. R7's September 29, 2024, AL Nursing Assessment indicated R6 had wound care and wound care coordination with hospice. The	01940		

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01940	Continued From page 31 assessment lacked a comprehensive assessment of the wound. On December 9, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-B stated wound care was not on the facilities signed service plan. It was on the Residential Services Plan provided by the county. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	02040		

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02040	Continued From page 32 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12/12/2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that	02110		

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02110	Continued From page 33 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required for assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for four of four residents (R2, R5, R6, R13). 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).	02110		

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02110	Continued From page 34 The findings include: The licensee had an assisted living with dementia care license effective August 1, 2021. R2, R5, R6, and R13's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On December 9, 2025, at 3:30 p.m., licensed assisted living director (LALD)-A stated the facility	02110		

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02110	Continued From page 35 had developed the ten dementia care policies, but she was unaware they needed to be provided to the residents upon admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for the licensee's one resident (R12) with a consumer grab bar. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 10, 2025, at 9:10 a.m., the	02310		

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02310	Continued From page 36 surveyor observed R12 had a consumer grab bar on her bed. The grab bar was a large U-shaped bar with legs that extended to the ground and a U-shaped bar that slid between the box spring and mattress. There was no strap securing the bar to the opposite side of the bed. R12 was admitted and began receiving assisted living services on February 27, 2023. R12's diagnoses included cerbrovascular accident (stroke). R12's unsigned service agreement printed December 10, 2025, indicated R12's services included medication administration and "VA (vulnerable adult) risk unapproved bed rail use". "Resident/Responsible party have been made aware of risks related to non-compliance with bed rail/side rail/grab bar in place. They choose to continue to use despite the acknowledged risks. Resident/Responsible party have been made aware of risks related to non-compliance with bed rail/side rail/grab bar in place. They choose to continue to use despite the acknowledged risks." R12's record included information for the consumer grab bar but did not include installation instructions for use of the grab bar. R12's Bed Rail Assessment dated April 18, 2025, indicated R12 had a U-shaped consumer bed rail and it was attached securely to the bed. The measurement within the rail was 35.5 inches. The assessment indicated the bed rail was installed per manufacturer instructions and the Consumer Product Safety Commission (CSPC) web site had been checked for recalls. R12's AL (assisted living) Nursing Assessment dated October 6, 2025, indicated R12 had a bed	02310		

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02310	Continued From page 37 rail/side rail/grab bar and "VA - FDA NOT compliant bed rail/side rail/grab bar: U shaped grab bar, has a history of left sided hemiparesis. Uses to to aid in bed mobility in and out of bed and within her bed like turning side to side". The assessment lacked evidence that it continued to be installed properly and the CSPC had been checked for recalls. On December 10, 2025, at 9:48 a.m., clinical nurse supervisor (CNS)-B stated she was unsure how often the CSPC was checked for recalls. At 10:52 a.m., CNS-B further stated the nursing staff would not be able to confirm the grab bar was installed according to manufacturer instructions since they did not have manufacturer instructions for installation. CNS-B was unaware the grab bar needed an assessment to include bed rails were installed according to manufacturer instructions and the CSPC had been checked for recalls every 90 days. The MDH web site, Assisted Living Resources & FAQs indicated; - licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed	02310		

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02310	Continued From page 38 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. - Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc. - Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. - If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly. This results in an imminent safety risk for the resident/client. - Licensees should review the CSPC web site regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

ECUMEN WORTHINGTON THE MEADOWS
1801 College Way
Worthington, MN 56187
Nobles County
Parcel:

Phone:

License Info

License: HFID 20011

Risk:
License:
Expires on:
CFPM: Nancy Kay Ward
CFPM #: 42898; Exp: 3/1/2028

Inspection Info

Report Number: F7990251022
Inspection Type: Full - Single
Date: 12/8/2025 Time: 10:49:10 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery:

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: REPLACE TORN DOOR GASKET ON THE MIDDLE DOOR OF THE TRUE 3 DOOR REACH IN COOLER.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

New Order: 4-500 Equipment Maintenance and Operation
4-502.13 *Priority Level: Priority 3 CFP#: 45*
MN Rule 4626.0830 Discontinue re-use of any single-service and single-use articles.
COMMENT: DISCONTINUE THE RE-USE OF SINGLE USE SOUR CREAM CONTAINERS BEING USED FOR FOOD STORAGE IN THE SOUTH KITCHEN TRAULSEN REACH IN COOLER.
Comply By: 12/22/2025 Originally Issued On: 12/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: CLEAN AND MAINTAIN CLEAN THE INSIDE BOTTOM OF THE ARCTIC AIR REACH IN FREEZER.
Comply By: 12/15/2025 Originally Issued On: 12/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-303.11B *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1470B Provide at least 20 foot candles (215 LUX) of light intensity at a distance of 30 inches from the floor for areas where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged foods are sold or offered for consumption, inside equipment including reach-in and under counter refrigerators, in utensil storage areas, warewashing areas, and in toilet rooms.
COMMENT: REPLACE BURNT OUT LIGHT BULBS INSIDE ARCTIC AIR REACH IN FREEZER AND VICTORY REACH IN FREEZER.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, COOLING, NOROVIRUS PREVENTION AND HANDWASHING. AN EMPLOYEE ILLNESS LOG WAS ONSITE.

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 F7990251022 from 12/8/2025

Benjamin D. Ische

Nancy Kay Ward

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
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Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

ECUMEN WORTHINGTON THE MEADOWS
Worthington
County/Group: Nobles County

Inspection Info

Report Number: F7990251022
Inspection Type: Full
Date: 12/8/2025
Time: 10:49:10 AM

Food Temperature: Product/Item/Unit: Hoshizaki Reach in Cooler Chili**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: True Glass 3 Door Reach in Cheese**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Undercounter Cooler**; Temperature Process:** Ambient Air
Location: Under Counter Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: South Kitchen Traulsen Cooler Pears**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: South Kitchen Reach in Condiment Cooler**; Temperature Process:** Ambient Air
Location: Reach-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

ECUMEN WORTHINGTON THE MEADOWS
Worthington
County/Group: Nobles County

Inspection Info

Report Number: F7990251022
Inspection Type: Full
Date: 12/8/2025
Time: 10:49:10 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 174 Degrees F.
Comment: Main Kitchen
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 165 Degrees F.
Comment: South Kitchen Dish Machine
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL20011016-0	**Date:** 12/12/2025
Facility Name: Ecumen Worthington	
Facility Address: 1801 Collegeway, Worthington, MN 56187	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: 1) Fire rated doors to the second-floor mechanical room and resident rooms 238 and 229 in the South building and the storage room by the garage in the North building had overhead door closers removed. ESD-H stated that several resident rooms had the door closers removed. 2) In the North building resident rooms 123, 112, 211 and the second-floor trash room had fire rated doors with spring hinges that did not fully close and latch the doors. 3) Second-floor laundry and the library in the North building had fire rated doors that were held open with wood wedges. When the wedges were removed the doors did not fully close and latch.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: Exit doors from the South building dining room led to a patio in the rear of the building. There was no pathway in the snow leading to a public way. The North building stairway exit by resident room 225 was the same.

4. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: The North building resident rooms 109 and 206 did not have carbon monoxide alarms. ESD-H stated that the resident rooms in the North building had plug-in style alarms, and the residents must have removed them from these rooms. None of the resident rooms in the memory care wing had carbon monoxide alarms.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: Surveyor requested the safety risk assessment from ESD-H and RFM-I at 1:18 p.m. RFM-I stated at 1:23 that the facility did not have a safety risk assessment.