Electronically Delivered

May 4, 2026

Licensee
Speltz Estates Assisted Living
232 Fremont Street South
Lewiston, MN 55952

RE: Project Number(s) SL30387016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
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
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(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: SL30387016-0 On April 6, 2026, through April 8, 2026, 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 11 residents; 11 receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on April 6, 2026, at a level 3/Widespread (I). The licensee took action on April 6, 2026; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted to the assisted living facility on October 30, 2024, with diagnoses including history of stroke, hypertension, and memory loss. R1's Service Plan dated August 2, 2025, indicated she received services including assistance with ambulation, bathing, grooming,	0 630		

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0 630	Continued From page 2 drinking, medication administration/management, and safety checks. R1's Individual Abuse Prevention Plan dated March 24, 2026, identified R1 was susceptible to abuse from others including other vulnerable adults; however, lacked interventions to minimize her risk of abuse from others. On April 8, 2026, at 12:35 p.m., clinical nurse supervisor (CNS)-H stated she missed including interventions when creating and updating R1's IAPP and would update it with the appropriate information. The licensee's Vulnerable Adult Maltreatment policy dated August 1, 2022, indicated that each resident receiving nursing services will have a written individualized abuse prevention plan. The plain would include: a. Residents' potential to abuse another individual/vulnerable adult; b. Resident's risk of abusing other vulnerable adults; c. Interventions to minimize the risk of abuse to the residents and other vulnerable adults No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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:	0 775		

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0 775	Continued From page 3 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 April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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

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0 810	Continued From page 5 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 April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 6 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care when the emergency relocation lasted longer than four days for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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	01060		

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01060	Continued From page 7 a large portion or all of the residents). The findings include: R5 was admitted to the facility on September 6, 2024, with diagnoses of type 2 diabetes, coronary heart disease and peripheral vascular disease. R5's record included a fall report dated December 15, 2025, and indicated R5 had a witnessed fall in the dining room, fell on his right hip, indicated pain and was transported by ambulance to the hospital. R5's progress notes included an entry on December 23, 2025, indicated "pt [patient] lost balance while getting up from dining room table and fell on right hip. Pt was unable to bear weight on right leg, ambulance was called. right hip fx [fracture]." R5's hospital discharge summary dated December 29, 2025, indicated R5 was hospitalized from December 15, 2025, to December 29, 2025, for a right hip fracture repair following a witnessed fall. R5's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;	01060		

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01060	Continued From page 8 - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. In addition, R5's records lacked notification to the Office of Ombudsman for Long-Term Care, the resident had been relocated and had not returned to the facility within four days. On April 7, 2026, at 10:20 a.m., licensed assisted living director (LALD)-A stated she was not aware of the requirements regarding a resident's emergency relocation and the need to notify the Office of Ombudsman for Long-Term Care. The licensee's Emergency Relocation policy (found in the Termination Policy) dated August 1, 2022, indicated this facility may remove a resident from the facility in an emergency, if necessary, due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. - In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: -The reason for the relocation -The name and contact information for the location to which the resident has been relocated and any new service provider -Contact information for the Office of Ombudsman for Long-Term Care -If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known	01060		

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01060	Continued From page 9 -A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal -The notice required will be delivered as soon as practicable to: 1. The resident, legal representative, and designated representative 2. For residents who receive home and community-based waiver services under the resident's case manager 3. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
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 label a time sensitive medication with an opened date for three of three residents (R2, R6, R9) with time sensitive	01890		

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01890	Continued From page 10 medications. 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 included: R2 R2's Service Plan dated August 1, 2025, included the services of medication management/administration. R2's signed prescriber's orders dated February 10, 2026, indicated Admelog (lispro) 100 units/milliliter (u/ml), give 7 units at breakfast, 9 units at lunch, 8 units at dinner with blood sugar at 140 and below, plus a sliding scale insulin indicating when blood sugar is: 141-155-give additional 1 unit insulin 156-170-give additional 2 units insulin 171-185-give additional 3 units insulin 186-200-give additional 4 units insulin 201-215-give additional 5 units insulin 216-230-give additional 6 units insulin 231-245-give additional 7 units insulin 246-260-give additional 8 units insulin 261-275-give additional 9 units insulin 276-290-give additional 10 units insulin 291-305-give additional 11 units insulin greater than 305-call RN On April 6, 2026, at 12:55 p.m., the surveyor observed unlicensed personnel (ULP)-C pull R2's	01890		

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01890	Continued From page 11 Admelog flex pen from his locked medication drawer. She wiped the pen tip and attached the pen needle, observed R2 prime the pen with 2 units insulin and dialed the appropriate dose given his base dose and sliding scale. R2 was then self-injected the insulin under direct supervision by ULP-C. The surveyor observed the Admelog flex pen included an open date label; however, there was no date written to indicate when it was removed from the refrigerator and first used. ULP-C indicated she was not aware the pen required an open date once it was opened. R6 R6's Service Plan dated August 1, 2025, indicated he received the service of medication administration/management. R6's signed prescriber's orders dated November 14, 2025, indicated Trelegy Ellipta inhaler 200-62.5-25 micrograms (mcg), give one puff daily for chronic lung disease. On April 7, 2026, at 8:15 a.m., the surveyor observed ULP-C set up and administer R6's morning medications. The surveyor observed R6's Trelegy Ellipta inhaler to include an open date label with no date written on it. In addition, the inhaler included the statement "discard after six weeks." ULP-C stated she had not noticed the open date label and was not aware of the time limit for the inhaler once it was opened. R9 R9's Service Plan dated August 1, 2025, indicated she received the service of medication administration/management. R9's signed prescriber's orders dated February	01890		

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	30387	A. BUILDING: _____ B. WING _____	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

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01890	Continued From page 12 26, 2026, indicated Tresiba flex pen 100 u/ml, give 80 units subcutaneously daily. On April 7, 2026, at 10:30 a.m., the surveyor and ULP-G reviewed the contents of R9's medication drawer. R9's Tresiba flex pen was observed to have an open date label without a date written to indicate when it was opened. ULP-G stated she would not know when the pen was opened and put into use. ULP-G further stated she was familiar with the requirement to indicate an open date from her experience working at a nursing home. On April 7, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated she was not aware of the need to indicate an open date for insulin pens. Admelog flex pen manufacturer's instructions dated 2026, only use your pen for up to 28 days after its first use. Throw away the ADMELOG Solostar pen you are using after 28 days, even if it still has insulin left in it. Tresiba insulin pen manufacturer's instructions dated 2025, indicated store at room temperature and use within 8 weeks (56 days). Trelegy inhaler manufacturer's instructions dated 2023 indicated Discard TRELEGY ELLIPTA 6 weeks after opening the foil tray. The licensee's Storage of Medications policy dated August 1, 2022, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength	01890		

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01890	Continued From page 13 and quantity of drug, expiration date of time-dated drug, directions of use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

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01940	Continued From page 14 monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R8) with treatments/delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 6, 2026, at 11:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R8 was admitted to the facility on May 31, 2018, with diagnoses including traumatic brain injury (TBA), dysphagia (difficulty with swallowing), and spastic hemiplegia (paralysis of one side of body) with contractures (unable to maintain joint alignment).	01940		

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01940	Continued From page 15 R8's Service Plan dated August 1, 2025, included assistance with prosthetic device. On April 7, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F assist R8 with morning cares (dressing, bathing, toileting). During the course of morning cares, ULP-F removed a wrist/hand/finger/orthosis (WHFO) (prosthetic brace) from R8's left wrist/hand. ULP-F stated R8 wore the brace during the night and during afternoon naptime. R8's Service Recap Summary (used for service documentation) dated April 2026, indicated "prosthetic device" for times including 1:00 p.m. and 6:00 p.m. R8's RN Assessment dated March 24, 2026, indicated his need for assistance with a WHFO brace. No further information/additional instruction was provided. R8's record included signed treatment orders dated June 10, 2025, indicated prosthetic brace twice daily. The licensee failed to include written instructions for R8's WHFO and what staff should monitor for (redness, open skin areas) and report to nursing. On April 8, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-H stated she knew to write additional instructions for the treatment of wound care; however, had not been doing so for other treatments the residents had. CNS-H stated she would review each resident receiving services in the facility and ensure all treatments included specific instructions for staff to reference in what to report to nursing.	01940		

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01940	Continued From page 16 The licensee's Delegation of Nursing Tasks dated August 1, 2022, indicated nursing tasks will be appropriately delegated to unlicensed personnel, using the licensed nurse's professional judgment. Additionally, the RN would develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes 144.4793, subd. 3 - Instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the unlicensed personnel have demonstrated the ability to competently follow the procedures; and - Develop written specific instructions for each resident and document those instructions in the resident's record No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for	02310		

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02310	Continued From page 17 the licensee's one resident (R1) who had a consumer bed rail. This resulted in an immediate correction order on April 6, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 6, 2026, at 11:30 a.m. during entrance conference, licensed assisted living director (LALD)-A stated she was aware of the requirements for a hospital bed rail system, stating the licensee had no hospital bed rails; however, one resident did have a "standing bar" attached to her bed. LALD-A further stated she was not aware the licensee needed to complete an assessment for bed rail safety, discuss risks verses benefits of bedrail use, have the manufacturer's instructions to ensure proper installation and use, or check for safety recalls with the consumer product safety commission (CPSC). R1 was admitted to the assisted living facility on October 30, 2024, with diagnoses including history of stroke, hypertension, and memory loss. R1's Service Plan dated August 2, 2025, indicated she received services including assistance with ambulation, bathing, grooming, drinking, medication administration/management, and safety checks.	02310		

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02310	Continued From page 18 On April 6, 2026, at 12:10 p.m. during a facility tour with LALD-A, the surveyor noted R1's electric bed to include a U-shaped consumer bedrail that included a horizontal bar across the middle creating two open areas above the mattress. The bedrail also included a U-shaped bar that was slid between the mattress and box spring. The bar (between the mattress and box spring) was not secured to the bed and could be moved when pressed against or pulled. LALD-A stated R1's family provided and placed the consumer bedrail, but she was not sure when. LALD-A stated R1 used the bedrail to push off when sitting on the side of the bed to a standing position. LALD-A and the surveyor observed the bedrail system and were unable to determine information regarding the manufacturer. Additionally, LALD-A stated there was a pressure sensitive floor mat placed where R1 would get out of bed to alert staff she was attempting to get up independently. R1's record included the most current registered nurse (RN) assessment dated March 24, 2026, which indicated R1 required assistance when walking and had a balance problem while standing and walking. R1's assessment further indicated R1 had an "electric bed with a memory foam mattress, and no assistive devices needed for bed." The assessment also indicated, "the bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed." The licensee failed to ensure the RN assessed R1's ability to safely use the consumer bedrail system, failed to discuss risks verses benefits of using the bed rail system, failed to determine the manufacturer and ensure the bedrail system was installed per manufacturer's instructions or check	02310		

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02310	Continued From page 19 for safety recalls. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The MDH website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "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 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences;	02310		

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02310	Continued From page 20 - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On April 6, 2026, the licensee took immediate action; however, the scope and level remains at I.	02310		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Speltz Estates Assisted Living
232 FREMONT STREET SOUTH
Lewiston, MN 55952
Winona County
Parcel:

Phone:

License Info

License: HFID 30387

Risk:
License:
Expires on:
CFPM: Michele Speltz
CFPM #: FM33272; Exp: 4/18/2027

Inspection Info

Report Number: F1009261075
Inspection Type: Full - Single
Date: 4/7/2026 Time: 10:30:24 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Discussion:

Lunch is served at noon.

Foods come from approved sources.
.
QA sanitizer concentrations are monitored and logged daily to ensure the concentration is maintained at 200ppm to 400ppm. Test strips are on site.

The NSF hot-water sanitizing dishmachine is monitored with heat sensitive labels.

Cooler temperatures are monitored and recorded on a log sheet. Corrective actions are noted when temperatures require adjustment. Food cook temperatures are monitored with a tip sensitive, thin stemmed food thermometer which is calibrated with an ice bath regularly. It is recommended to also check foods inside the coolers with the food thermometer regularly to detect if the ambient air cooler thermometer has lost accuracy.

When cooling takes place, foods are placed in shallow metal pans into the cooler uncovered. There is a procedure in place for checking food temperatures through the cooling process.

Foods are thawed while under refrigeration.

Plunkett's services the facility for pest management. No signs of pests seen today.

The water heater pressure relief valve terminates within 18 inches of the floor as required.

There is an air gap where the water softener discharge line terminates into the floor utility tub. Keep an eye on this line to ensure the air gap is maintained, and that it does not fall below the flood rim of the utility tub.

Please be aware that Norovirus, often thought to be the "stomach flu" continues to be the leading cause of foodborne illness outbreaks. A person who has contracted Norovirus continues to be contagious at least three days after symptoms have subsided. Because of this, it is important to report and record any illnesses, even if staff did not report to work while ill.
Also, to further reduce the risk of transmitting Norovirus and other pathogens, continue to closely monitor hand washing, proper cleaning and sanitizing of equipment and surfaces, and do not allow bare-hand contact with ready-to-eat foods.

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 Rochester District Office inspection report number F1009261075 from 4/7/2026

Lesli Haines

Michele Speltz

Lesli Haines,
Public Health Sanitarian 3
507-206-2745
lesli.haines@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30387016-0	**Date:** April 7, 2026
Facility Name: Speltz Estates Asst. Living	
Facility Address: 232 FREMONT ST, LEWISTON, MN	

☒ **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: Several resident rooms and other facility fire doors no longer closed and latched.

3. The emergency power system shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   Comments: The facility emergency mounted lighting system failed to operate when tested.

4. 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: A marked exit door across from a facility office was blocked with a bookshelf.

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed assisted living director (LALD)-A lacked documentation showing training was offered twice in 2025 for staff on the fire safety and evacuation plan.

4. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed assisted living director (LALD)-A lacked documentation showing any training was offered in 2025 for residents on the fire safety and evacuation plan.