Electronically Delivered

August 8, 2025

Licensee
Generations Child & Memory Care LLC
3631 Hoffman Road
Mankato, MN 56001

RE: Project Number(s) SL38588016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 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 2: a fine of $500 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

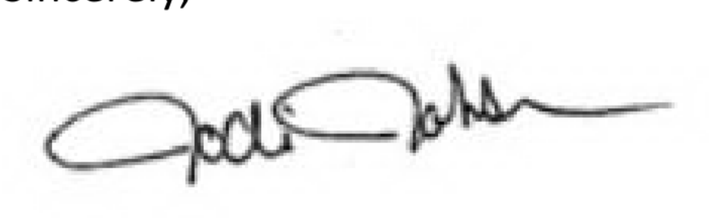
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38588	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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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: SL38588016-0 On June 9, 2025, through June 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 20 residents; 20 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, June 11, 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		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person 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 two 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's diagnoses included dementia (the loss of the	0 630		

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0 630	Continued From page 4 ability to think, remember, and reason to levels that affect daily life and activities). R1's unsigned, service plan printed June 10, 2025, indicated R1 received assistance with grooming, bathing, toileting, ambulation, compression stockings, respiratory equipment care, housekeeping, laundry, and medication administration. R1's Individual Abuse Prevention Plan (IAPP) dated March 17, 2025, failed to include: -the person's risk of abusing other vulnerable adults In addition, R1's IAPP indicated R1 was at risk to be abused; however, the licensee did not implement interventions to minimize her abuse by others, including other vulnerable adults. On June 10, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B reviewed R1's IAPP and stated it did not included the above required content. The licensee's 6.03 Individual Abuse Prevention Plan policy dated January 1, 2024, indicated: 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 5 days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of two employees (unlicensed personnel (ULP)-E). 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	0 660		

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0 660	Continued From page 6 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: The licensee's TB facility risk assessment dated July 17, 2024, indicated the licensee was a low risk. ULP-E was hired September 21, 2023, to provide direct care services. On June 10, 2025, at 7:46 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record did not include evidence a TB symptom screen had been completed. On June 11, 2025, at 12:39 p.m., clinical nurse supervisor (CNS)-B stated current protocol for new hires is to initiate/complete the TB symptom screen with the new employee prior to official hire. ULP-E had been hired prior to this protocol change and CNS-B was unaware her record did not include a TB symptom screen. The licensee's 8.14 Tuberculosis Screening policy dated January 1, 2024, indicated: Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after	0 660		

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0 660	Continued From page 7 a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 8 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 develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on June 9, 2024, at 10:23 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - subsistence needs for staff and residents during emergency situations to include: - medical supplies - pharmaceutical supplies - emergency lighting - development of policies/procedures to address:	0 680		

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0 680	Continued From page 9 - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On June 11, 2025, at 1:51 p.m., licensed assisted living director (LALD)-A reviewed the emergency preparedness binder and could not find evidence of the above required content. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated January 1, 2024, indicated: The licensee's emergency preparedness plan will include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730		

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0 730	Continued From page 10 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730		

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0 730	Continued From page 11 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3's record lacked a discharge summary to include: - course of illnesses - treatments and therapies - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R3 was admitted to the licensee on September 3, 2024, with diagnoses including Lewy body dementia. R3 discharged from the facility on November 22, 2024. On June 11, 2025, at 12:39 p.m., clinical nurse supervisor (CNS)-B reviewed R3's discharge	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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0 730	Continued From page 12 summary and stated it did not include all required components. The licensee's 1.08 Contract Termination policy dated January 1, 2024, indicated: Step 7 - Resident Discharge Summary a. At the time of discharge, the licensee will provide the resident, and, with the resident's consent, the resident's representatives and case manager, with a written discharge summary that includes: - A summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results. - A final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baselines and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and	0 775		

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0 775	Continued From page 13 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On June 10, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-G. During the tour, the surveyor observed: EXIT OBSTRUCTION: The rear marked exit leads to a large fenced in area which includes the daycare playground. There is a personnel gate, near the facility exit door, with a lock on it preventing egress to the public way. The exit to the public way, shall provide a direct and unobstructed access. CONTROLLED EGRESS Controlled egress doors throughout the facility, surveyor asked LALD-A/DM-G the location of the switch or device that unlocks all doors. A signal or switch to unlock the egress doors was not found or was not known by staff. MN Fire code states, egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. During a facility tour on June 10, 2025, at 12:30	0 775		

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0 775	Continued From page 14 p.m., LALD-A/DM-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 15 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 of the emergency relocation for one of one resident who was hospitalized (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's unsigned, service plan effective June 9, 2025, indicated R2 received services which included medication administration, assistance with dressing, grooming, toileting, bathing, ambulation, escort/mobility assistance, compression stockings, CPAP (continuous positive airway pressure) machine, behavior monitoring, laundry, and housekeeping.	01060		

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01060	Continued From page 16 R2's progress notes indicated R2 was hospitalized on January 10, 2025, due to a fall with a right hip fracture. The progress notes further indicated R2 returned to the licensee on January 15, 2025, five days later. R2's record lacked 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; - 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. In addition, R2's record 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 June 10, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated being unaware of the requirement to provide a written notice of emergency relocation when residents are hospitalized. CNS-B stated licensed assisted living director (LALD)-A may be providing this. On June 10, 2025, at 2:27 p.m., LALD-A stated he had not been providing a written notice of emergency relocation to the	01060		

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01060	Continued From page 17 resident/representative and also to the ombudsman if greater than four days and was unaware of the requirement. The licensee's 1.10 Emergency Relocation policy dated January 1, 2024, indicated: 1. In the event of an emergency relocation, the licensee will provide a written notice that contains at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided.	01060		

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01060	Continued From page 18 TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 19 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-F) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired July 31, 2024, to provide direct care services. On June 10, 2025, at 7:33 a.m., the surveyor observed ULP-F applying compression stockings to R4 and assisting with morning cares. ULP-F's employee record lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided. - understanding appropriate boundaries between	01370		

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01370	Continued From page 20 staff and residents and the resident's family. On June 11, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A and business office director (BOD)-D reviewed ULP-F's employee file and could not locate evidence the above trainings had been completed. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2024, indicated: 5. Training and competency evaluations for all ULPs will include: a. Documentation requirements for all services m. Understanding appropriate boundaries between staff and residents and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 21 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01470	Continued From page 22 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one new unlicensed personnel (ULP-F) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F was hired July 31, 2024, to provide direct care services. On June 10, 2025, at 7:33 a.m., the surveyor observed ULP-F applying compression stockings to R4 and assisting with morning cares. ULP-F's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - overview of assisted living statutes; - review of provider's policies and procedures; - handling of resident complaints, reporting of	01470		

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01470	Continued From page 23 complaints, where to report; and - consumer advocacy services. On June 11, 2025, at 11:50 a.m. licensed assisted living director (LALD)-A and business office director (BOD)-D reviewed ULP-F's employee record and stated it did not include evidence of the above trainings. LALD-A and BOD-D further stated these trainings were not a part of their orientation training. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated January 1, 2024, indicated: All staff of [licensee name] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing Assisted Living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500		

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01500	Continued From page 24 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

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GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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01500	Continued From page 25 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on September 21, 2023, to provide direct care services under the licensee's assisted living with dementia care license. On June 10, 2025, at 7:46 a.m., the surveyor observed ULP-E administering medications to R1. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01500	Continued From page 26 On June 11, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated being unable to find evidence the above annual training had been completed as required. The licensee's 5.04 Annual Required Staff Training policy dated January 1, 2024, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	01620		

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01620	Continued From page 27 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 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last	01620		

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01620	Continued From page 28 assessment, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, depression, anxiety, Crohn's disease, and asthma. R1's unsigned, service plan printed June 10, 2025, indicated R1 received assistance with grooming, bathing, toileting, ambulation, compression stockings, respiratory equipment care, housekeeping, laundry, and medication administration. R1's last three assessments were requested. Assessments completed December 2, 2024, December 16, 2024, and March 17, 2025, were provided. 91 days had passed between the December 16, 2024, and March 17, 2024, assessments (one day late). On June 10, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated R1's March 2025, assessment had not been completed within 90 days. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated January 1, 2024, indicated: 3. Resident reassessment and monitoring must	01620		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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01620	Continued From page 29 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. 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 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	01640		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01640	Continued From page 30 by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan within 14 calendar days for one of two residents (R1); and failed to ensure a written service plan was signed when revised to reflect the current services provided for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 was admitted on December 2, 2024, with diagnoses including dementia, depression, anxiety, Crohn's disease, and asthma. On June 10, 2025, at 7:46 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. R1's unsigned, service plan printed June 10, 2025, indicated R1 received assistance with grooming, bathing, toileting, ambulation, compression stockings, respiratory equipment care, housekeeping, laundry, and medication administration. R1's record lacked a service plan that had been signed/authenticated by the resident/resident	01640		

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01640	Continued From page 31 representative and facility staff within 14 days of the start of services. On June 10, 2025, at 10:57 a.m., an email was sent by the surveyor to licensed assistant living director (LALD)-A and clinical nurse supervisor (CNS)-B requesting R1's signed service plan. At 11:13 a.m., the surveyor received an email from CNS-B indicating the licensee was unable to locate a signed service plan for R1 since admission. R2 R2 was admitted on October 26, 2022, with diagnoses including vascular dementia and edema. R2's service plan signed October 26, 2022, indicated R2 received services which included medication administration, assistance with dressing, grooming, toileting, transfers, bathing, ambulation, escort/mobility assistance, CPAP (continuous positive airway pressure) machine, behavior monitoring, laundry, and housekeeping. The service plan further indicated R2's services were rated Package: Level 2 for cost. R2's unsigned, service plan effective June 9, 2025, indicated R2 received services which included medication administration, assistance with dressing, grooming, toileting, transfers, bathing, ambulation, escort/mobility assistance, compression stockings, CPAP machine, behavior monitoring, laundry, and housekeeping. The unsigned service plan further indicated R2's services were rated Package: Level 4 for cost. On June 10, 2025, at 8:00 a.m. the surveyor observed ULP-E administering medications to R2.	01640		

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01640	Continued From page 32 On June 9, 2025, at 4:05 p.m., CNS-B stated R2's services had changed since admission. CNS-B further stated R2's service plan in the electronic record was current; although it had not been signed/authenticated by R2's representative or the licensee. The licensee's 6.06 Service Plan Modifications policy dated January 1, 2024, indicated: If the service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the service plan modification form will be completed; this form includes: -Describe changes in service and whether the service is added (new), changed, or discontinued -Frequency of new service or if service terminated -Identification of the staff who will perform the service -Schedule and methods of monitoring staff -Fee for the service -Date/Signature of RN (registered nurse) making changes -Date/signature of resident or the resident's representative each time a modification is made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730		

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01730	Continued From page 33 management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01730	Continued From page 34 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two 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: During the entrance conference on June 9, 2025, at 10:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included dementia, depression, anxiety, Crohn's disease (inflammatory bowel disease), hyponatremia (low sodium level in blood), hypothyroidism (low thyroid levels in blood), hypercholesterolemia (high cholesterol), periodic limb movement disorder (PLMD), post nasal drip, macular degeneration, and asthma. R1's unsigned, service plan printed/effective June 10, 2025, indicated R1 received services including medication administration.	01730		

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01730	Continued From page 35 R1's provider orders dated June 2, 2025, included four supplements, two for anxiety, one for thyroid, two for post nasal drip, one for pain, one for PLMD, one for Crohn's disease, one for macular degeneration, one for edema, one for hyponatremia, one for hypercholesterolemia, and three for asthma. On June 10, 2025, at 7:46 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1; this included oral medications and an inhaler. R1's most recent assessment by the registered nurse (RN), and R1's Individualized Medication Management Plan, each dated March 17, 2025, indicated: Medication management tasks that may be delegated to unlicensed personnel: inhaler. On June 10, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B reviewed R1's current assessment and individualized medication management plan and stated they were inaccurate as ULPs that were medication trained were able to administer all medication routes as ordered. The licensee's 7.02 Medication Management Individualized Plan policy dated January 1, 2024, noted the RN would develop and maintain a current individualized medication management record for each resident based on the resident's assessment. Qualified unlicensed personnel who have been delegated the responsibility by an RN may administer medication, whether orally, by suppository, through eye drips, ear drops, by use of an inhalant, topically, by infection as ordered by physician.	01730		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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01730	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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01790	Continued From page 37 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of one employees (unlicensed personnel (ULP)-E) providing medications for residents with unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a	01790		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

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01790	Continued From page 38 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 included: ULP-E was hired on September 21, 2023, to provide direct care services under the licensee's assisted living with dementia care license. On June 10, 2025, at 7:46 a.m., the surveyor observed ULP-E administering medications to R1. ULP-F's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On June 11, 2025, at 12:39 p.m., registered nurse (RN)-C stated ULPs who were trained to administer medications were also trained how to set-up medications for unplanned time away. RN-C further stated nursing had developed a checklist for medication administration training for ULPs that included this procedure; however, the checklist had been developed after ULP-C had been hired and trained, so it may not be a part of her employee file. The licensee's 7.07 Medication Management - Planned & Unplanned Time Away policy dated January 1, 2024, indicated: For unplanned resident time away when a pharmacist or licensed nurse is not available, the	01790		

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01790	Continued From page 39 Registered Nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=E	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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38588	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS CHILD & MEMORY CARE LLC	3631 HOFFMAN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on June 9, 2025, at 10:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the licensee's residents. R1 R1's diagnoses included dementia, nocturnal hypoxia (decrease in blood oxygen levels during sleep), bilateral lower extremity edema (swelling), and asthma. R1's provider visit note dated June 2, 2025,	01940		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01940	Continued From page 41 included the following orders: - Knee-high compression stockings 15-20 mmHg (compression level), apply in AM, remove in PM - Oxygen, apply nasal cannula 2.5 L (liters) at bedtime R1's unsigned, service plan printed/effective June 10, 2025, indicated R1 received services including assistance with compression stockings and respiratory equipment care R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services specific to oxygen and compression stockings. R2 R2's diagnoses included vascular dementia and edema. R2's provider visit note dated June 2, 2025, included the following order: -Men's Compression Stockings Knee High 15-20 MMHG: On in AM and off in PM. R2's unsigned, service plan printed/effective June 9, 2025, indicated R2 received services including assistance with compression stockings. R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services specific to the compression stocking. On June 10, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated she had not been adding specific direction to unlicensed staff on	01940		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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01940	Continued From page 42 when to contact the RN for issues with oxygen or compression stockings. The licensee's 7.03 Treatment & Therapy Management Plan policy dated January 1, 2024, indicated: F. The RN will prepare an individualized treatment or therapy management plan for each client receiving ordered or prescribed treatment or therapy services, which addresses c. Procedures for monitoring treatment or therapies to prevent possible complications or adverse reactions. e. Procedures for notifying the RN when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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.	02040		

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	38588	A. BUILDING: _____ B. WING _____	06/11/2025

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02040	Continued From page 43 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct mitigation for hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: During record review on June 10, 2025, from 10:30 a.m. to 12:30 p.m., with licensed assisted living director (LALD)-A. The licensee failed to provide mitigation for the hazards on the hazard vulnerability assessment (HVA). Facility did have a HVA completed with percentages assigned to each vulnerability, the assessment was missing mitigations to take when and if those hazards happened. On June 10, 2025, at 1:30 p.m. LALD-A stated they understood the requirements and would implement mitigations for hazards identified on HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=C	144G.82 Subd. 3 Policies	02110		

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02110	Continued From page 44 (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 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	02110		

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02110	Continued From page 45 licensee failed to ensure policies and procedures required in 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 two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: The facility held an Assisted Living with Dementia Care license. R1 and R2'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 nonpharmacological 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;	02110		

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02110	Continued From page 46 - 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 June 9, 2025, at 1:32 p.m., licensed assisted living director (LALD)-A stated they did not provide residents/legal representative or designated representative the dementia policies and procedures at the time of move-in, and was unaware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by:	02140		

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02140	Continued From page 47 Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 9, 2025, at 10:23 a.m., licensed assisted living director (LALD)-A stated being unaware of the training requirements for staff oversight related to dementia care training. LALD-A stated he would check into dementia training completed by himself and supervisory staff to see if it would qualify. On June 11, 2025, at 10:04 a.m., LALD-A stated not having a designated staff member who had completed the supervisory dementia training as required. The licensee's 5.03 Dementia Training policy dated January 1, 2024, indicated: 4. A qualified trainer or supervisor must be available for consultation with new employees until training is complete. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21)	02140		

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02140	Continued From page 48 days	02140		

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

Generations Memory Care
3631 Hoffman Rd
Mankato, MN 56001
Blue Earth County
Parcel:

Phone:

License Info

License: 38588
Dwight Aalgaard
Risk:
License:
Expires on:
CFPM: Dwight Aalgaard
CFPM #: FM123631; Exp: 03/19/2027

Inspection Info

Report Number: F1028251035
Inspection Type: Full - Single
Date: 6/11/2025 Time: 12:43:56 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: **An Employee Illness Log must be maintained privately on-site.**
Comply By: 6/11/2025 Originally Issued On: 6/11/2025

Food & Beverage General Comment

This Inspection was conducted in conjunction with HRD. All food is catered in from Schuur Tasty Catering in Mankato. Staff from Generations Memory Care serve the food to residents.

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 F1028251035 from 6/11/2025

Dwight Aalgaard
Director

Ryan Miller, RS
Public Health Sanitarian 3
507-344-2721
ryan.miller@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

Generations Memory Care
Mankato
County/Group: Blue Earth County

Inspection Info

Report Number: F1028251035
Inspection Type: Full
Date: 6/11/2025
Time: 12:43:56 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 185 Degrees F.
Comment:
Violation Issued?: No