Electronically Delivered

October 10, 2025

Licensee
American Eagle Owatonna
364 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30823016

Dear Licensee:

Please note: This letter amends previous letter dated October 8, 2025. Specifically tag 1970 was amended to reflect a change in the resident (R1 was changed to R2). No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on August 27, 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.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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: SL30823016-0 On August 25, 2025, through August 27, 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 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license. 1970: This citation was amended to reflect a change in the resident (R1 was changed to R2) that was previously noted in the survey results.	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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. 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: The licensee had an assisted living with dementia care license, effective December 1, 2024. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and	0 420		

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0 420	Continued From page 2 Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on December 2, 2024. As a result of this survey, the following orders were issued under 0480, 0680, 0730, 0775, 0810, 0900, 0950, 1370, 1380, 1500, 1540, 1610, 1620, 1640, 1750, 1820, 1910, 1940, 1960, 1970, 2040, 2140, and 2170 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	0 480		

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0 480	Continued From page 3 (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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480		

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0 480	Continued From page 4 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 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, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 680	Continued From page 5	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual Memory Care, undated, was reviewed and lacked the following: -arrangement with other faculties (including sister facilities); -evidence the licensee reviewed their Missing Resident plan on a quarterly basis On August 27, 2025, at 11:48 a.m., director of engineering (DOE)-G reviewed the emergency preparedness manual and stated it lacked the required content as noted above. The licensee's Disaster Planning and Emergency Preparedness policy dated October 6, 2022, indicated 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 emergency. All of these elements are incorporated into the Appendix Z requirements. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 7	0 730		
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; (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	0 730		

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0 730	Continued From page 8 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 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 include the required content in a discharge summary 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 was admitted to the licensee on November 30, 2024, and discharged on December 5, 2024. R3's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results;	0 730		

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0 730	Continued From page 9 -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On August 27, 2025, at 10:17 a.m., licensed assisted living director (LALD)-A stated the previous LALD and clinical nurse supervisor (CNS) had "transferred" R3 from the Assisted Living sister facility to the licensee for a few days after an event occurred in the Assisted Living and they were concerned about R3's safety. LALD-A stated the previous staff did not consider this move an admission, but rather a transfer; therefore, did not complete the admission process which included a discharge summary when she returned to the Assisted Living sister facility. The licensee's Resident Record- Information and Content policy dated September 28, 2022, indicated the resident record would include a discharge summary, to include the following: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies,	0 730		

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0 730	Continued From page 10 treatments ad therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, an ay arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTION: 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 11 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 August 26, 2025, from 11:00 p.m. to 2:30 p.m., the surveyor toured the facility with director of engineering (DOE)-G. During the tour, the surveyor observed: CARBON MONOXIDE ALARM Facility has single station battery powered carbon monoxide alarms mounted to walls of both hallways outside of resident rooms. Carbon monoxide alarms were not mounted all the way down the hallway, several rooms on both sides of the hallway had no carbon monoxide detection. Carbon monoxide alarms should be within 10' on the outside of the sleeping room. CONTROLLED EGRESS Controlled egress doors throughout the facility, surveyor asked DOE-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.	0 775		

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0 775	Continued From page 12 During a facility tour on August 26, 2025, at 1:30 p.m., DOE-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	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; (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	0 810		

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0 810	Continued From page 13 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 develop the fire safety and evacuation plan with the required content and provide the required training. 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 potential to affect a large portion or all of the residents). The findings include: On August 26, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with the director of engineering (DOE)-G. During the tour, the surveyor observed; surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for staff, residents and visitor accessibility. August 26, 2025, from 11:00 a.m. to 2:30 p.m., with DOE-G; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 14 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated 5/30/24, failed to include the following: STAFF ACTIONS: 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). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On August 26, 2025, at 1:30 p.m., DOE-G stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 15 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of three residents (R1 and 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	0 900		

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0 900	Continued From page 16 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. R1's record lacked a written contract. R3 R3 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a written contract. On August 26, 2025, at 9:27 a.m., licensed assisted living director (LALD)-A stated both R1 and R3 had previously resided at their sister Assisted Living facility. LALD-A reviewed R1's record and stated it contained a written contract for the Assisted Living sister facility; however, it lacked a written contract for the current licensee. LALD-A reviewed R3's record and stated it lacked a written contract. LALD-A stated the previous LALD, and clinical nurse supervisor (CNS) had "transferred" R3 from the Assisted Living sister facility to the licensee for a few days after an event occurred in Assisted Living and they were concerned about R3's safety. LALD-A stated the previous staff did not consider this move an admission, but instead a transfer and so did not complete the admission process which included a written contract. No further information was provided.	0 900		

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0 900	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950		

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0 950	Continued From page 18 Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract. This had the potential to affect all residents. 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: Page 18 of the licensee's Assisted Living with Dementia Care Contract included an area to designate or decline a designated representative; however, the contract failed to include the verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On August 27, 2025, at 10:20 a.m., licensed assisted living director (LALD)-A reviewed the license's contract and stated it did not include the	0 950		

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0 950	Continued From page 19 correct verbiage for designated representative. LALD-A further stated the same contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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	01370		

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01370	Continued From page 20 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 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 interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) 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-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence of training for the following topics: -documentation requirements for all services	01370		

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01370	Continued From page 21 provided; -reports of changes in the resident's condition to the supervisor designated by the facility; and -understanding appropriate boundaries between staff and residents and the resident's family On August 27, 2025, at 10:37 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it lacked documentation of the training and competency evaluations as listed above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -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		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 22 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) 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-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents.	01380		

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01380	Continued From page 23 ULP-E's employee record lacked evidence of training for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel On August 27, 2025, at 10:37 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it lacked documentation of the training and competency evaluations as listed above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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	01500		

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01500	Continued From page 24 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 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	01500		

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01500	Continued From page 25 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, 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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment 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 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 June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence the employee had successfully completed annual	01500		

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	30823	A. BUILDING: _____ B. WING _____	08/27/2025

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01500	Continued From page 26 training as required, to include the following: - a review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in 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; - review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. On August 27, 2025, at 10:44 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it did not contain the required annual training as listed above. The licensee's Annual Required Staff Training policy dated September 27, 2022, indicated the following training elements must be included every 12 months to all staff who performs direct care services: 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 the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 27 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 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 6. Principles of person-centered planning and service delivery ad how they apply to direct support services provided by the staff person No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the	01540		

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01540	Continued From page 28 training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D and ULP-E) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: The licensee provided services under an Assisted Living Facility with Dementia Care license. ULP-D ULP-D was hired on December 10, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record contained evidence	01540		

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01540	Continued From page 29 the employee received seven hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-D's employee record lacked evidence of completing any mental illness, and de-escalation training. ULP-E ULP-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence the employee received two hours of dementia care training annually as required. On August 27, 2025, at 10:47 a.m., licensed assisted living director (LALD)-A reviewed ULP-D and ULP-E's employee record and stated ULP-D and ULP-E had not completed the required training as noted above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Dementia Training Policy dated September 27, 2022, indicated all staff were required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01610	Continued From page 30	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of three residents (R3) prior to the initiation of 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 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).	01610		

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01610	Continued From page 31 The findings include: R3 R3 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a written contract and service plan. R3's progress notes dated November 30, 2024, indicated R3 moved to the licensee and started to receive services on November 30, 2024. R3's Greenbrier Evaluation (comprehensive nurse assessment) was completed on December 2, 2024 (two days after the start of services). On August 27, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated R3 was "transferred" to the licensee from their sister Assisted Living facility after an event occurred and they were concerned for R3's safety. LALD-A stated the prior clinical nurse supervisor (CNS) should have completed an initial assessment the day R3 started services with the licensee. The licensee's Assessments, Reviews and Monitoring policy dated September 27, 2022, indicated the licensee would 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.	01610		

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01610	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
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 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.	01620		

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01620	Continued From page 33 (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) conducted timely ongoing nursing assessments for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 34 R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's assessments dated November 11, 2024, December 5, 2024, March 5, 2025, and June 3, 2025, were reviewed. The December 5, 2024, assessment was completed 24 days after the date of admission, thus exceeding the required reassessment at 14 calendar days. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's assessments dated November 13, 2024, November 26, 2024, March 5, 2025, and June 3, 2025, were reviewed. The March 5, 2025, assessment was completed	01620		

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01620	Continued From page 35 99 days after the date of the previous assessment, thus exceeding 90 calendar days. On August 27, 2025, at 10:04 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R1 and R2's assessments and stated they were not completed within the required time frame. ICNS-B stated she had completed an audit of all resident assessments and had a plan in place to ensure all assessments were completed timely. Licensed assisted living director (LALD)-A stated the nurse that completed the late assessments no longer worked for the licensee. The licensee's Assessments, Reviews and Monitoring policy dated September 27, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident ad 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=D	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	01640		

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01640	Continued From page 36 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 by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally The findings include: R1 R1 was admitted on November 11, 2024, with	01640		

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01640	Continued From page 37 diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications with nectar thickened fluids and check R1's blood sugar. The surveyor noted R1 had bilateral compression stockings on at this time. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received treatment services to include compression stockings R1's medication administration record (MAR) dated August 2025, included: -Requires mildly thick liquids- nectar thick liquids and minced and moist food every shift for special diet R1's prescriber orders included: -Nutrition: dysphagia diet and thickened liquids, order dated July 14, 2025 -discontinue compression wraps and stockings, order dated August 5, 2025 R1's record lacked prescriber orders to wear compression stockings. R1's service plan did not include compression stockings, dysphagia (modified diet for	01640		

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01640	Continued From page 38 individuals with difficulty swallowing) diet or nectar thickened liquids. On August 27, 2025, at 10:11 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 previously wore bilateral compression stockings; however, they were discontinued on August 5, 2025. ICNS-B stated compression stockings were never added to R1's service plan when he did require them, so when they were discontinued, a new service plan was not needed as compression stockings weren't listed as a service. ICNS-B stated she would update the staff to ensure they knew R1 no longer wore them. ICNS-B stated R1's service plan did not include dysphagia diet or nectar thickened liquids. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's MAR dated August 2025, included: -Nectar thick liquids for all fluids every shift for ease with swallowing	01640		

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01640	Continued From page 39 R2's prescriber orders included: -start a pureed texture diet for ease with swallowing, order dated July 31, 2025 -start mildly thickened nectar liquids for ease with swallowing, order dated August 14, 2025 R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. On August 27, 2025, at 10:15 a.m., ICNS-B stated R2's service plan did not include puree diet or nectar thickened liquids. The licensee's Service Plan policy dated September 28, 2022, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
01750	Continued From page 40 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for two of two residents (R1 and R2) whose medication administration was delegated to unlicensed personnel (ULP). 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 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:42 a.m., the surveyor observed ULP-C administer medications to R1. R1's service plan dated July 14, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR)	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01750	Continued From page 41 dated August 2025, included: -calcium antacid 500 milligrams (mg); chew 1-2 tablets by mouth every four hours as needed for heartburn, order dated July 14, 2025 The licensee failed to have resident-specific instructions regarding when to give one tablet versus two tablets of calcium carbonate. CONSTIPATION: R1's MAR dated August 2025, included the following as needed (PRN) medications for constipation: -senna-docusate sodium 8.6-50 mg; give one tablet by mouth as needed for constipation daily, order dated July 14, 2025 -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily, order dated July 15, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. PAIN R1's MAR dated August 2025, included the following PRN medications for pain: -acetaminophen 500 mg; give two tablets orally every 24 hours as needed, order dated July 14, 2025 -acetaminophen 650 mg; insert one suppository rectally every six hours as needed for mild pain or fever, order dated July 14, 2025 -Morphine 5 mg; give 5 mg by mouth every one hour as needed for pain or shortness of breath, order dated July 15, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for	01750		

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01750	Continued From page 42 pain should be used in which order. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include medication administration. CONSTIPATION R2's MAR dated August 2025, included the following PRN medications for constipation: -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily, order dated July 28, 2025 -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily (duplicate order), order dated July 28, 2025 -polyethylene glycol powder 17 grams; give 17 grams orally every 24 hours as needed for constipation, order dated July 28, 2025 -stimulant laxative 8.6-50 mg; give one tablet orally as needed for constipation daily, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. PAIN R2's MAR dated August 2025, included the following PRN medications for pain: -acetaminophen 650 mg; insert 650 mg rectally	01750		

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01750	Continued From page 43 every six hours as needed for mild pain or fever, order dated July 28, 2025 -Morphine 5 mg; give 10 mg sublingually every two hours as needed for pain or shortness of breath, order dated August 6, 2025 NAUSEA/VOMITING R2's MAR dated August 2025, included the following medications for nausea/vomiting: -prochlorperazine 25 mg suppository; insert one suppository rectally as needed for nausea or vomiting two times daily, order dated July 28, 2025 -prochlorperazine maleate 10 mg; give one tablet orally every six hours as needed for nausea/vomiting, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for nausea/vomiting should be used in which order. SHORTNESS OF BREATH -ipratropium/albuterol solution; one vial inhale orally via nebulizer every six hours as needed for shortness of breath, order dated July 28, 2025 -Morphine 5 mg; give 10 mg sublingually every two hours as needed for pain or shortness of breath, order dated August 6, 2025 -Ventolin HFA inhaler; give one puff orally every four hours as needed for shortness of breath, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for shortness of breath should be used in which order. On August 27, 2025, at 10:09 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 and	01750		

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01750	Continued From page 44 R2's medication orders and stated there were no written instructions regarding R1 and R2's medications as listed above. ICNS-B stated she was in the process of auditing all resident medication orders to ensure specific resident instructions were included for the ULP. The licensee's Medication and Treatment-Administration and Delegation policy dated September 27, 2022, indicated a RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for one of three residents (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	01820		

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01820	Continued From page 45 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 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a service plan. R3's medication administration record (MAR) dated December 2024, indicated R3 received the following medications: -aspirin 81 milligrams (mg); give one tablet by mouth in the morning (heart health) -donepezil 5 mg; give one tablet by mouth at bedtime (dementia) -lisinopril 20 mg; give one tablet by mouth in the morning (blood pressure) -paroxetine 20 mg; give one tablet by mouth at bedtime (depression) -metformin 1,000 mg; give one tablet by mouth two times a day (diabetes) -quetiapine 25 mg; give one tablet orally two times a day (depression) -acetaminophen 500 mg; give two tablets by mouth every eight hours as needed (pain) -melatonin 3 mg; give one tablet by mouth every 24 hours as needed (sleep) -quetiapine 25 mg; give one tablet by mouth every 12 hours as needed (restlessness/agitation) R3's record lacked signed prescriber orders for the medications listed above.	01820		

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01820	Continued From page 46 On August 27, 2025, at 10:12 a.m., licensed assisted living director (LALD)-A stated R3's record lacked signed prescriber orders. The licensee's Medications and Treatment Orders policy dated September 28, 2022, indicated the registered nurse (RN) was responsible for assuring that a current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents" records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 47 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required 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 was admitted to the licensee on November 30, 2024, and discharged on December 5, 2024. R3's medication administration record (MAR) dated December 2024, indicated R3 received the following medications: -aspirin 81 milligrams (mg); give one tablet by mouth in the morning (heart health) -donepezil 5 mg; give one tablet by mouth at bedtime (dementia) -lisinopril 20 mg; give one tablet by mouth in the morning (blood pressure) -paroxetine 20 mg; give one tablet by mouth at bedtime (depression) -metformin 1,000 mg; give one tablet by mouth two times a day (diabetes) -quetiapine 25 mg; give one tablet orally two	01910		

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01910	Continued From page 48 times a day (depression) -acetaminophen 500 mg; give two tablets by mouth every eight hours as needed (pain) -melatonin 3 mg; give one tablet by mouth every 24 hours as needed (sleep) -quetiapine 25 mg; give one tablet by mouth every 12 hours as needed (restlessness/agitation) R3's record lacked a medication disposition record at the time of discharge to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 27, 2025, at 10:17 a.m., licensed assisted living director (LALD)-A reviewed R3's record and stated it did not include a disposition of medications. The licensee's medication Disposal policy dated September 28, 2022, indicated the licensee shall dispose of any medications remaining with the licensee that are discontinued or expired or upon the termination of the service contract or the resident's death according to the state and federal regulations for disposition of medications and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 49 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, 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 and R2).	01940		

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01940	Continued From page 50 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 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications with nectar thickened fluids and check R1's blood sugar. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's service plan did not include compression stockings, dysphagia (modified diet for individuals with difficulty swallowing) diet or nectar thickened liquids. R1's medication administration record (MAR) dated August 2025, included: -Requires mildly thick liquids- nectar thick liquids and minced and moist food every shift for special diet R1's prescriber orders included:	01940		

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01940	Continued From page 51 -Nutrition: dysphagia diet and thickened liquids, order dated July 14, 2025 R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received the following treatments: -Diabetic Care: blood glucose monitoring -Diabetic Care: foot/nail care -Compression stockings -Vital Signs R1's Treatment and Therapy Management Plan lacked the following required content: -statement of the type of service that will be provided (dysphagia diet thickened liquids) R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. R2's MAR dated August 2025, included: -Nectar thick liquids for all fluids every shift for east with swallowing	01940		

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01940	Continued From page 52 R2's prescriber orders included: -start a pureed texture diet for ease with swallowing, order dated July 31, 2025 -start mildly thickened nectar liquids for ease with swallowing, order dated August 14, 2025 R2's Minnesota Treatment and Therapy Plan dated July 3, 2025, indicated R2 received the following treatments: -Oxygen management -Oxygen saturation checks -Compression stockings -Blood pressure checks -Vital signs R2's Treatment and Therapy Management Plan lacked the following required content: -statement of the type of service that will be provided (puree diet and thickened liquids) On August 27, 2025, at 10:14 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R1 and R2's treatment and therapy management plans and stated they did not include the treatment services as noted above. The licensee's Treatment and Therapy Management Plan policy dated September 27, 2022, indicated a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that	01940		

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01940	Continued From page 53 will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for	01960		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 54 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 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:27 a.m., the surveyor observed R1 wearing compression stockings. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's service plan did not include compression stockings, dysphagia (modified diet for individuals with difficulty swallowing) diet or nectar thickened liquids. R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received treatment services to include compression stockings. R1's record lacked prescriber orders to wear compression stockings.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

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01960	Continued From page 55 R1's record included prescriber orders dated August 5, 2025, to discontinue compression wraps and stockings. R1's scheduled services document dated August 2025, did not include compression stockings. R1's record lacked documentation of compression stockings services. On August 27, 2025, at 10:16 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 had previously worn bilateral compression stockings, which she could not locate the prescriber orders for. ICNS-B stated R1 no longer required compression stockings, and they were discontinued on August 5, 2025. ICNS-B stated R1's service plan and treatment and therapy management plan should have been updated to reflect the compression stockings being discontinued. On August 27, 2025, at 10:43 a.m., ICNS-B removed R1's bilateral compression stockings and explained to R1 that he no longer needed to wear them. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated September 28, 2022, indicated the license would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water.	01970		

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01970	Continued From page 57 R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. R2's prescriber orders included: -oxygen via nasal cannula 1-3 liters per minute continuous to keep oxygen levels at 88% and above, order dated August 7, 2025 R2's record lacked prescriber orders for oxygen saturation (O2 SATs) checks. R2's medication administration record (MAR) dated August 2025, included: -Oxygen vial nasal cannula 1-3 liters per minute (LPM) continuous to keep oxygen levels at 88% and above, and oxygen saturation checks every shift The licensee failed to provide instructions for the ULP to understand when to administer one, two, or three liters of oxygen when R2's O2 saturations are below 88% and how often R2's O2 saturations need to be re-checked to ensure O2 SATs rise above 88%. On August 27, 2025, at 10:15 a.m., interim clinical nurse supervisor (ICNS)-B stated the licensee used R2's oxygen order dated August 7, 2025, as the order for R2's oxygen saturation checks. ICNS-B stated the oxygen order did not specifically indicate to check R2's O2 SATs every	01970		

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01970	Continued From page 58 shift; however, ICNS-B felt it was implied to keep R2's O2 SATs above 88%. ICNS-B stated the licensee did not have a separate order to check R2's O2 SATs that included a frequency. Further, ICNS-B stated R2's record failed to include specific instructions for the ULP on when to administer one, two or three liters of oxygen and if O2 saturation checks would need to be repeated to ensure O2 saturations were above 88%. The licensee's Medication and Treatment Orders policy dated September 28, 2022, indicated residents who receive medication management services by [licensee name] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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	02040		

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02040	Continued From page 59 approved supervised automatic sprinkler system by August 1, 2029. 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: On August 26, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with the director of engineering (DOE)-G. 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 August 26, 2025, at 1:30 p.m. DOE-G stated they understood the requirements and would implement mitigations for hazards identified on HVA. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 60 (21) days.	02040		
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: 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 the residents). The findings include: During the entrance conference on August 25, 2025, at 9:40 a.m., licensed assisted living director (LALD)-A stated both her and the clinical nurse supervisor (CNS) oversaw the staff training in the care of individuals with dementia; however,	02140		

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02140	Continued From page 61 the CNS was no longer employed at the licensee. On August 27, 2025, at 10:31 a.m., the surveyor reviewed the LALD training transcript through Relias which contained completed dementia care courses. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed, and Relias trainings were not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On August 27, 2025, at 10:31 a.m., the surveyor showed LALD the list of approved Dementia care training programs. LALD-A stated she had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care. The licensee's Dementia Training policy dated September 27, 2022, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the	02170		

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02170	Continued From page 62 following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop	02170		

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02170	Continued From page 63 an individualized activity plan based on the evaluation, for two of two residents (R1 and R2) who received services under the assisted living with dementia care license and resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee had an assisted living with dementia care license. R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:42 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's Minnesota Activity Assessment dated December 2, 2024, did not include the following required content:	02170		

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02170	Continued From page 64 - emotional and social needs and patterns; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's Minnesota Activity Assessment dated November 22, 2024, did not include the following required content: - emotional and social needs and patterns; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment.	02170		

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02170	Continued From page 65 On August 27, 2025, at 10:26 a.m., licensed assisted living director (LALD)-A stated R1 and R2's evaluation lacked the above required components. LALD-A further stated none of the residents had an activity plan based on the evaluation. LALD-A stated the licensee had recently hired a new Activity Director who will be in charge of completing all resident activity evaluations and activity plans to meet the requirements. The licensee's Assisted Living with Dementia Care Life Enrichment Programs, Activities and Outdoor Space policy dated September 27, 2022, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: -past and current interest -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions An individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Electronically Delivered

October 8, 2025

Licensee
American Eagle Owatonna
364 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30823016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL30823016-0 On August 25, 2025, through August 27, 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 21 residents; 21 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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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	30823	A. BUILDING: _____ B. WING _____	08/27/2025

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. 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: The licensee had an assisted living with dementia care license, effective December 1, 2024. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and	0 420		

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0 420	Continued From page 2 Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on December 2, 2024. As a result of this survey, the following orders were issued under 0480, 0680, 0730, 0775, 0810, 0900, 0950, 1370, 1380, 1500, 1540, 1610, 1620, 1640, 1750, 1820, 1910, 1940, 1960, 1970, 2040, 2140, and 2170 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	0 480		

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0 480	Continued From page 3 (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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480		

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0 480	Continued From page 4 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 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, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 680	Continued From page 5	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual Memory Care, undated, was reviewed and lacked the following: -arrangement with other faculties (including sister facilities); -evidence the licensee reviewed their Missing Resident plan on a quarterly basis On August 27, 2025, at 11:48 a.m., director of engineering (DOE)-G reviewed the emergency preparedness manual and stated it lacked the required content as noted above. The licensee's Disaster Planning and Emergency Preparedness policy dated October 6, 2022, indicated 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 emergency. All of these elements are incorporated into the Appendix Z requirements. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 7	0 730		
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; (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	0 730		

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0 730	Continued From page 8 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 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 include the required content in a discharge summary 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 was admitted to the licensee on November 30, 2024, and discharged on December 5, 2024. R3's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results;	0 730		

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0 730	Continued From page 9 -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On August 27, 2025, at 10:17 a.m., licensed assisted living director (LALD)-A stated the previous LALD and clinical nurse supervisor (CNS) had "transferred" R3 from the Assisted Living sister facility to the licensee for a few days after an event occurred in the Assisted Living and they were concerned about R3's safety. LALD-A stated the previous staff did not consider this move an admission, but rather a transfer; therefore, did not complete the admission process which included a discharge summary when she returned to the Assisted Living sister facility. The licensee's Resident Record- Information and Content policy dated September 28, 2022, indicated the resident record would include a discharge summary, to include the following: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies,	0 730		

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0 730	Continued From page 10 treatments ad therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, an ay arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTION: 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 11 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 August 26, 2025, from 11:00 p.m. to 2:30 p.m., the surveyor toured the facility with director of engineering (DOE)-G. During the tour, the surveyor observed: CARBON MONOXIDE ALARM Facility has single station battery powered carbon monoxide alarms mounted to walls of both hallways outside of resident rooms. Carbon monoxide alarms were not mounted all the way down the hallway, several rooms on both sides of the hallway had no carbon monoxide detection. Carbon monoxide alarms should be within 10' on the outside of the sleeping room. CONTROLLED EGRESS Controlled egress doors throughout the facility, surveyor asked DOE-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.	0 775		

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0 775	Continued From page 12 During a facility tour on August 26, 2025, at 1:30 p.m., DOE-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	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; (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	0 810		

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0 810	Continued From page 13 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 develop the fire safety and evacuation plan with the required content and provide the required training. 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 potential to affect a large portion or all of the residents). The findings include: On August 26, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with the director of engineering (DOE)-G. During the tour, the surveyor observed; surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for staff, residents and visitor accessibility. August 26, 2025, from 11:00 a.m. to 2:30 p.m., with DOE-G; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 14 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated 5/30/24, failed to include the following: STAFF ACTIONS: 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). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On August 26, 2025, at 1:30 p.m., DOE-G stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 15 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of three residents (R1 and 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	0 900		

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0 900	Continued From page 16 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. R1's record lacked a written contract. R3 R3 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a written contract. On August 26, 2025, at 9:27 a.m., licensed assisted living director (LALD)-A stated both R1 and R3 had previously resided at their sister Assisted Living facility. LALD-A reviewed R1's record and stated it contained a written contract for the Assisted Living sister facility; however, it lacked a written contract for the current licensee. LALD-A reviewed R3's record and stated it lacked a written contract. LALD-A stated the previous LALD, and clinical nurse supervisor (CNS) had "transferred" R3 from the Assisted Living sister facility to the licensee for a few days after an event occurred in Assisted Living and they were concerned about R3's safety. LALD-A stated the previous staff did not consider this move an admission, but instead a transfer and so did not complete the admission process which included a written contract. No further information was provided.	0 900		

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0 900	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950		

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0 950	Continued From page 18 Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract. This had the potential to affect all residents. 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: Page 18 of the licensee's Assisted Living with Dementia Care Contract included an area to designate or decline a designated representative; however, the contract failed to include the verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On August 27, 2025, at 10:20 a.m., licensed assisted living director (LALD)-A reviewed the license's contract and stated it did not include the	0 950		

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0 950	Continued From page 19 correct verbiage for designated representative. LALD-A further stated the same contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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	01370		

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01370	Continued From page 20 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 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 interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) 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-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence of training for the following topics: -documentation requirements for all services	01370		

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01370	Continued From page 21 provided; -reports of changes in the resident's condition to the supervisor designated by the facility; and -understanding appropriate boundaries between staff and residents and the resident's family On August 27, 2025, at 10:37 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it lacked documentation of the training and competency evaluations as listed above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -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		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 22 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) 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-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents.	01380		

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01380	Continued From page 23 ULP-E's employee record lacked evidence of training for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel On August 27, 2025, at 10:37 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it lacked documentation of the training and competency evaluations as listed above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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	01500		

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01500	Continued From page 24 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 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	01500		

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01500	Continued From page 25 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, 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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment 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 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 June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence the employee had successfully completed annual	01500		

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01500	Continued From page 26 training as required, to include the following: - a review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in 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; - review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. On August 27, 2025, at 10:44 a.m., licensed assisted living director (LALD)-A reviewed ULP-E's employee record and stated it did not contain the required annual training as listed above. The licensee's Annual Required Staff Training policy dated September 27, 2022, indicated the following training elements must be included every 12 months to all staff who performs direct care services: 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 the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 27 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 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 6. Principles of person-centered planning and service delivery ad how they apply to direct support services provided by the staff person No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the	01540		

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01540	Continued From page 28 training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D and ULP-E) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: The licensee provided services under an Assisted Living Facility with Dementia Care license. ULP-D ULP-D was hired on December 10, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record contained evidence	01540		

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01540	Continued From page 29 the employee received seven hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-D's employee record lacked evidence of completing any mental illness, and de-escalation training. ULP-E ULP-E was hired on June 16, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked evidence the employee received two hours of dementia care training annually as required. On August 27, 2025, at 10:47 a.m., licensed assisted living director (LALD)-A reviewed ULP-D and ULP-E's employee record and stated ULP-D and ULP-E had not completed the required training as noted above. LALD-A stated the licensee completed an audit of all employee files after their sister facility had a survey and have now updated the training plan and assigned courses for all staff to complete to meet the training requirements. The licensee's Dementia Training Policy dated September 27, 2022, indicated all staff were required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01610	Continued From page 30	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of three residents (R3) prior to the initiation of 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 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).	01610		

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01610	Continued From page 31 The findings include: R3 R3 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a written contract and service plan. R3's progress notes dated November 30, 2024, indicated R3 moved to the licensee and started to receive services on November 30, 2024. R3's Greenbrier Evaluation (comprehensive nurse assessment) was completed on December 2, 2024 (two days after the start of services). On August 27, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated R3 was "transferred" to the licensee from their sister Assisted Living facility after an event occurred and they were concerned for R3's safety. LALD-A stated the prior clinical nurse supervisor (CNS) should have completed an initial assessment the day R3 started services with the licensee. The licensee's Assessments, Reviews and Monitoring policy dated September 27, 2022, indicated the licensee would 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.	01610		

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01610	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
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 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.	01620		

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01620	Continued From page 33 (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) conducted timely ongoing nursing assessments for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 34 R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's assessments dated November 11, 2024, December 5, 2024, March 5, 2025, and June 3, 2025, were reviewed. The December 5, 2024, assessment was completed 24 days after the date of admission, thus exceeding the required reassessment at 14 calendar days. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's assessments dated November 13, 2024, November 26, 2024, March 5, 2025, and June 3, 2025, were reviewed. The March 5, 2025, assessment was completed	01620		

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01620	Continued From page 35 99 days after the date of the previous assessment, thus exceeding 90 calendar days. On August 27, 2025, at 10:04 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R1 and R2's assessments and stated they were not completed within the required time frame. ICNS-B stated she had completed an audit of all resident assessments and had a plan in place to ensure all assessments were completed timely. Licensed assisted living director (LALD)-A stated the nurse that completed the late assessments no longer worked for the licensee. The licensee's Assessments, Reviews and Monitoring policy dated September 27, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident ad 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=D	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	01640		

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01640	Continued From page 36 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 by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally The findings include: R1 R1 was admitted on November 11, 2024, with	01640		

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01640	Continued From page 37 diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications with nectar thickened fluids and check R1's blood sugar. The surveyor noted R1 had bilateral compression stockings on at this time. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received treatment services to include compression stockings R1's medication administration record (MAR) dated August 2025, included: -Requires mildly thick liquids- nectar thick liquids and minced and moist food every shift for special diet R1's prescriber orders included: -Nutrition: dysphagia diet and thickened liquids, order dated July 14, 2025 -discontinue compression wraps and stockings, order dated August 5, 2025 R1's record lacked prescriber orders to wear compression stockings. R1's service plan did not include compression stockings, dysphagia (modified diet for	01640		

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01640	Continued From page 38 individuals with difficulty swallowing) diet or nectar thickened liquids. On August 27, 2025, at 10:11 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 previously wore bilateral compression stockings; however, they were discontinued on August 5, 2025. ICNS-B stated compression stockings were never added to R1's service plan when he did require them, so when they were discontinued, a new service plan was not needed as compression stockings weren't listed as a service. ICNS-B stated she would update the staff to ensure they knew R1 no longer wore them. ICNS-B stated R1's service plan did not include dysphagia diet or nectar thickened liquids. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's MAR dated August 2025, included: -Nectar thick liquids for all fluids every shift for ease with swallowing	01640		

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01640	Continued From page 39 R2's prescriber orders included: -start a pureed texture diet for ease with swallowing, order dated July 31, 2025 -start mildly thickened nectar liquids for ease with swallowing, order dated August 14, 2025 R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. On August 27, 2025, at 10:15 a.m., ICNS-B stated R2's service plan did not include puree diet or nectar thickened liquids. The licensee's Service Plan policy dated September 28, 2022, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750		

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01750	Continued From page 40 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for two of two residents (R1 and R2) whose medication administration was delegated to unlicensed personnel (ULP). 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 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:42 a.m., the surveyor observed ULP-C administer medications to R1. R1's service plan dated July 14, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR)	01750		

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01750	Continued From page 41 dated August 2025, included: -calcium antacid 500 milligrams (mg); chew 1-2 tablets by mouth every four hours as needed for heartburn, order dated July 14, 2025 The licensee failed to have resident-specific instructions regarding when to give one tablet versus two tablets of calcium carbonate. CONSTIPATION: R1's MAR dated August 2025, included the following as needed (PRN) medications for constipation: -senna-docusate sodium 8.6-50 mg; give one tablet by mouth as needed for constipation daily, order dated July 14, 2025 -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily, order dated July 15, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. PAIN R1's MAR dated August 2025, included the following PRN medications for pain: -acetaminophen 500 mg; give two tablets orally every 24 hours as needed, order dated July 14, 2025 -acetaminophen 650 mg; insert one suppository rectally every six hours as needed for mild pain or fever, order dated July 14, 2025 -Morphine 5 mg; give 5 mg by mouth every one hour as needed for pain or shortness of breath, order dated July 15, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for	01750		

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01750	Continued From page 42 pain should be used in which order. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include medication administration. CONSTIPATION R2's MAR dated August 2025, included the following PRN medications for constipation: -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily, order dated July 28, 2025 -bisacodyl 10 mg suppository; insert one suppository rectally as needed for constipation daily (duplicate order), order dated July 28, 2025 -polyethylene glycol powder 17 grams; give 17 grams orally every 24 hours as needed for constipation, order dated July 28, 2025 -stimulant laxative 8.6-50 mg; give one tablet orally as needed for constipation daily, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. PAIN R2's MAR dated August 2025, included the following PRN medications for pain: -acetaminophen 650 mg; insert 650 mg rectally	01750		

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	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
01750	Continued From page 43 every six hours as needed for mild pain or fever, order dated July 28, 2025 -Morphine 5 mg; give 10 mg sublingually every two hours as needed for pain or shortness of breath, order dated August 6, 2025 NAUSEA/VOMITING R2's MAR dated August 2025, included the following medications for nausea/vomiting: -prochlorperazine 25 mg suppository; insert one suppository rectally as needed for nausea or vomiting two times daily, order dated July 28, 2025 -prochlorperazine maleate 10 mg; give one tablet orally every six hours as needed for nausea/vomiting, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for nausea/vomiting should be used in which order. SHORTNESS OF BREATH -ipratropium/albuterol solution; one vial inhale orally via nebulizer every six hours as needed for shortness of breath, order dated July 28, 2025 -Morphine 5 mg; give 10 mg sublingually every two hours as needed for pain or shortness of breath, order dated August 6, 2025 -Ventolin HFA inhaler; give one puff orally every four hours as needed for shortness of breath, order dated July 28, 2025 The licensee failed to provide instructions for the ULP to understand which PRN medication for shortness of breath should be used in which order. On August 27, 2025, at 10:09 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 and	01750		

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01750	Continued From page 44 R2's medication orders and stated there were no written instructions regarding R1 and R2's medications as listed above. ICNS-B stated she was in the process of auditing all resident medication orders to ensure specific resident instructions were included for the ULP. The licensee's Medication and Treatment-Administration and Delegation policy dated September 27, 2022, indicated a RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for one of three residents (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	01820		

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01820	Continued From page 45 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 was admitted on November 30, 2024, with diagnoses that included diabetes and depression. R3's record lacked a service plan. R3's medication administration record (MAR) dated December 2024, indicated R3 received the following medications: -aspirin 81 milligrams (mg); give one tablet by mouth in the morning (heart health) -donepezil 5 mg; give one tablet by mouth at bedtime (dementia) -lisinopril 20 mg; give one tablet by mouth in the morning (blood pressure) -paroxetine 20 mg; give one tablet by mouth at bedtime (depression) -metformin 1,000 mg; give one tablet by mouth two times a day (diabetes) -quetiapine 25 mg; give one tablet orally two times a day (depression) -acetaminophen 500 mg; give two tablets by mouth every eight hours as needed (pain) -melatonin 3 mg; give one tablet by mouth every 24 hours as needed (sleep) -quetiapine 25 mg; give one tablet by mouth every 12 hours as needed (restlessness/agitation) R3's record lacked signed prescriber orders for the medications listed above.	01820		

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01820	Continued From page 46 On August 27, 2025, at 10:12 a.m., licensed assisted living director (LALD)-A stated R3's record lacked signed prescriber orders. The licensee's Medications and Treatment Orders policy dated September 28, 2022, indicated the registered nurse (RN) was responsible for assuring that a current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents" records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 47 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required 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 was admitted to the licensee on November 30, 2024, and discharged on December 5, 2024. R3's medication administration record (MAR) dated December 2024, indicated R3 received the following medications: -aspirin 81 milligrams (mg); give one tablet by mouth in the morning (heart health) -donepezil 5 mg; give one tablet by mouth at bedtime (dementia) -lisinopril 20 mg; give one tablet by mouth in the morning (blood pressure) -paroxetine 20 mg; give one tablet by mouth at bedtime (depression) -metformin 1,000 mg; give one tablet by mouth two times a day (diabetes) -quetiapine 25 mg; give one tablet orally two	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 48 times a day (depression) -acetaminophen 500 mg; give two tablets by mouth every eight hours as needed (pain) -melatonin 3 mg; give one tablet by mouth every 24 hours as needed (sleep) -quetiapine 25 mg; give one tablet by mouth every 12 hours as needed (restlessness/agitation) R3's record lacked a medication disposition record at the time of discharge to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 27, 2025, at 10:17 a.m., licensed assisted living director (LALD)-A reviewed R3's record and stated it did not include a disposition of medications. The licensee's medication Disposal policy dated September 28, 2022, indicated the licensee shall dispose of any medications remaining with the licensee that are discontinued or expired or upon the termination of the service contract or the resident's death according to the state and federal regulations for disposition of medications and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 49 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, 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 and R2).	01940		

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01940	Continued From page 50 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 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications with nectar thickened fluids and check R1's blood sugar. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's service plan did not include compression stockings, dysphagia (modified diet for individuals with difficulty swallowing) diet or nectar thickened liquids. R1's medication administration record (MAR) dated August 2025, included: -Requires mildly thick liquids- nectar thick liquids and minced and moist food every shift for special diet R1's prescriber orders included:	01940		

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01940	Continued From page 51 -Nutrition: dysphagia diet and thickened liquids, order dated July 14, 2025 R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received the following treatments: -Diabetic Care: blood glucose monitoring -Diabetic Care: foot/nail care -Compression stockings -Vital Signs R1's Treatment and Therapy Management Plan lacked the following required content: -statement of the type of service that will be provided (dysphagia diet thickened liquids) R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. R2's MAR dated August 2025, included: -Nectar thick liquids for all fluids every shift for east with swallowing	01940		

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01940	Continued From page 52 R2's prescriber orders included: -start a pureed texture diet for ease with swallowing, order dated July 31, 2025 -start mildly thickened nectar liquids for ease with swallowing, order dated August 14, 2025 R2's Minnesota Treatment and Therapy Plan dated July 3, 2025, indicated R2 received the following treatments: -Oxygen management -Oxygen saturation checks -Compression stockings -Blood pressure checks -Vital signs R2's Treatment and Therapy Management Plan lacked the following required content: -statement of the type of service that will be provided (puree diet and thickened liquids) On August 27, 2025, at 10:14 a.m., interim clinical nurse supervisor (ICNS)-B reviewed R1 and R2's treatment and therapy management plans and stated they did not include the treatment services as noted above. The licensee's Treatment and Therapy Management Plan policy dated September 27, 2022, indicated a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that	01940		

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01940	Continued From page 53 will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for	01960		

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01960	Continued From page 54 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 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:27 a.m., the surveyor observed R1 wearing compression stockings. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's service plan did not include compression stockings, dysphagia (modified diet for individuals with difficulty swallowing) diet or nectar thickened liquids. R1's Minnesota Treatment and Therapy Plan dated July 14, 2025, indicated R1 received treatment services to include compression stockings. R1's record lacked prescriber orders to wear compression stockings.	01960		

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01960	Continued From page 55 R1's record included prescriber orders dated August 5, 2025, to discontinue compression wraps and stockings. R1's scheduled services document dated August 2025, did not include compression stockings. R1's record lacked documentation of compression stockings services. On August 27, 2025, at 10:16 a.m., interim clinical nurse supervisor (ICNS)-B stated R1 had previously worn bilateral compression stockings, which she could not locate the prescriber orders for. ICNS-B stated R1 no longer required compression stockings, and they were discontinued on August 5, 2025. ICNS-B stated R1's service plan and treatment and therapy management plan should have been updated to reflect the compression stockings being discontinued. On August 27, 2025, at 10:43 a.m., ICNS-B removed R1's bilateral compression stockings and explained to R1 that he no longer needed to wear them. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated September 28, 2022, indicated the license would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2 with nectar thickened water.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
01970	Continued From page 57 R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's service plan did not include puree (foods that have been blended or mashed to a smooth pudding-like consistency) diet or nectar thickened liquids. R2's prescriber orders included: -oxygen via nasal cannula 1-3 liters per minute continuous to keep oxygen levels at 88% and above, order dated August 7, 2025 R2's record lacked prescriber orders for oxygen saturation (O2 SATs) checks. R2's medication administration record (MAR) dated August 2025, included: -Oxygen vial nasal cannula 1-3 liters per minute (LPM) continuous to keep oxygen levels at 88% and above, and oxygen saturation checks every shift The licensee failed to provide instructions for the ULP to understand when to administer one, two, or three liters of oxygen when R1's O2 saturations are below 88% and how often R1's O2 saturations need to be re-checked to ensure O2 SATs rise above 88%. On August 27, 2025, at 10:15 a.m., interim clinical nurse supervisor (ICNS)-B stated the licensee used R1's oxygen order dated August 7, 2025, as the order for R1's oxygen saturation checks. ICNS-B stated the oxygen order did not specifically indicate to check R1's O2 SATs every	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
01970	Continued From page 58 shift; however, ICNS-B felt it was implied to keep R1's O2 SATs above 88%. ICNS-B stated the licensee did not have a separate order to check R1's O2 SATs that included a frequency. Further, ICNS-B stated R1's record failed to include specific instructions for the ULP on when to administer one, two or three liters of oxygen and if O2 saturation checks would need to be repeated to ensure O2 saturations were above 88%. The licensee's Medication and Treatment Orders policy dated September 28, 2022, indicated residents who receive medication management services by [licensee name] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
02040	Continued From page 59 approved supervised automatic sprinkler system by August 1, 2029. 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: On August 26, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with the director of engineering (DOE)-G. 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 August 26, 2025, at 1:30 p.m. DOE-G stated they understood the requirements and would implement mitigations for hazards identified on HVA. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 60 (21) days.	02040		
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: 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 the residents). The findings include: During the entrance conference on August 25, 2025, at 9:40 a.m., licensed assisted living director (LALD)-A stated both her and the clinical nurse supervisor (CNS) oversaw the staff training in the care of individuals with dementia; however,	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
02140	Continued From page 61 the CNS was no longer employed at the licensee. On August 27, 2025, at 10:31 a.m., the surveyor reviewed the LALD training transcript through Relias which contained completed dementia care courses. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed, and Relias trainings were not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On August 27, 2025, at 10:31 a.m., the surveyor showed LALD the list of approved Dementia care training programs. LALD-A stated she had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care. The licensee's Dementia Training policy dated September 27, 2022, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 62 following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 63 an individualized activity plan based on the evaluation, for two of two residents (R1 and R2) who received services under the assisted living with dementia care license and resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee had an assisted living with dementia care license. R1 R1 was admitted on November 11, 2024, with diagnoses that included age related cognitive decline and diabetes. On August 26, 2025, at 7:42 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's service plan dated July 14, 2025, indicated R1 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, safety checks, weights, vital signs, blood glucose checks, and medication administration. R1's Minnesota Activity Assessment dated December 2, 2024, did not include the following required content:	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 64 - emotional and social needs and patterns; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R2 R2 was admitted on November 13, 2024, with diagnoses that included age related cognitive decline. On August 26, 2025, at 7:27 a.m., the surveyor observed ULP-C administer medications to R2. R2's service plan dated July 3, 2025, indicated R2 received services to include bathing, hygiene/grooming, dressing, continence care, transfers, escorts, wound care, oxygen management, eating assistance, safety checks, weights, vital signs, oxygen management, and medication administration. R2's Minnesota Activity Assessment dated November 22, 2024, did not include the following required content: - emotional and social needs and patterns; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30823	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN EAGLE OWATONNA	364 CEDARDALE DRIVE SE OWATONNA, MN 55060

(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
02170	Continued From page 65 On August 27, 2025, at 10:26 a.m., licensed assisted living director (LALD)-A stated R1 and R2's evaluation lacked the above required components. LALD-A further stated none of the residents had an activity plan based on the evaluation. LALD-A stated the licensee had recently hired a new Activity Director who will be in charge of completing all resident activity evaluations and activity plans to meet the requirements. The licensee's Assisted Living with Dementia Care Life Enrichment Programs, Activities and Outdoor Space policy dated September 27, 2022, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: -past and current interest -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions An individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Food & Beverage Inspection Report

Establishment Info

American Eagle Owatonna
364 Cedardale Dr SE
Owatonna, MN 55060
Steele County
Parcel:

Phone:

License Info

License: HFID 30823

Risk:
License:
Expires on:
CFPM: Brittany L. Blouin
CFPM #: 76510; Exp: 03/03/2027

Inspection Info

Report Number: F8044251177
Inspection Type: Full - Single
Date: 8/26/2025 Time: 8:32:37 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 3-500A Microbial Control: cooling
3-501.15B *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.
COMMENT:
Creamed corn, beets and peas cooled in covered containers.
Comply By: 8/26/2025 Originally Issued On: 8/26/2025

! **New Order: 5-200B Plumbing: cross connections**
5-203.14A *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.
COMMENT:
Discharge hoses for water softeners below the flood rim of mop sink.
Comply By: 9/9/2025 Originally Issued On: 8/26/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT:
E-FECTicide used on counters in kitchen is not approved for food contact surfaces.
Comply By: 8/26/2025 Originally Issued On: 8/26/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Report reviewed on site with Brittany.

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 F8044251177 from 8/26/2025

Brittany Blouin

Michael DeMars, RS
Public Health Sanitarian III
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

American Eagle Owatonna
Owatonna
County/Group: Steele County

Inspection Info

Report Number: F8044251177
Inspection Type: Full
Date: 8/26/2025
Time: 8:32:37 AM

Food Temperature: Product/Item/Unit: Sausage gravy**; Temperature Process:** Hot-Holding
Location: Steam Table at 183.7 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Creamed corn**; Temperature Process:** Cold-Holding
Location: Upright Cooler 1 at 38.6 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 1 at 35.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Shredded cheddar**; Temperature Process:** Cold-Holding
Location: Upright Cooler 2 at 40.1 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 2 at 36.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

American Eagle Owatonna
Owatonna
County/Group: Steele County

Inspection Info

Report Number: F8044251177
Inspection Type: Full
Date: 8/26/2025
Time: 8:32:37 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 170.1 Degrees F.
Comment:
Violation Issued?: No