Electronically Delivered

November 18, 2025

Licensee
Minneota Assisted Living and Home Health Care
700 North Madison Street
Minneota, MN 56264

RE: Project Number(s) SL30459016

Dear Licensee:

On November 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 14, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

CLN

Electronically Delivered

October 3, 2025

Licensee
Minneota Assisted Living and Home Health Care
700 North Madison Street
Minneota, MN 56264

RE: Project Number(s) SL30459016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Minneota Assisted Living and Home Health Care. **Please contact Jodi Johnson at 507-344-2730 on or before October 6, 2025, to schedule the conference call.**

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
	30459	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

(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: SL30459016-0 On August 11, 2025, through August 14, 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 26 residents; 23 receiving services under the Assisted Living Facility license. 1290: An immediate correction order was identified on August 12, 2025, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	0 100		

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0 100	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of facility space by a third-party vendor to provide therapy services to residents and to outside community members. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 11, 2025, at 9:30 a.m. upon entering	0 100		

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0 100	Continued From page 3 the facility, the surveyor observed [name of therapy service] on the entrance doors, an unidentified person was exiting the building and heading toward the parking area. Upon entering the building, the surveyor observed [name of therapy service] by a door and after going through another door, observed [name of therapy service] on the first door to the left. During the entrance conference on August 11, 2025, at approximately 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. LALD-A stated the licensee did not employee physical or occupational therapists; however, an outside company provided physical therapy onsite. On August 14, 2025, at 10:08 a.m., clinical nurse supervisor (CNS)-B stated the therapy company provided therapy services to the public and to residents living in the facility, but very few of the licensee's residents were seen there. On August 14, 2025, at 10:25 a.m., LALD-A stated the therapy company rented the space and provides services to the public. LALD-A further stated the licensee had not completed an innovation variance request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 4 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for one of three employees (unlicensed personnel (ULP)-F). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 12, 2025, during continuous observation, the surveyor observed ULP-F completing the following tasks: - at 7:20 a.m., ULP-F entered R10's room, put on	0 510		

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0 510	Continued From page 5 gloves, set up medications for administration and administered the oral medications. ULP-F then applied a medicated lotion to R10's scalp. ULP-F removed the gloves, and left the room. ULP-F did not use hand sanitizer or wash her hands after glove removal. - at 7:28 a.m., ULP-F entered R11's room, put on gloves, set up medications for administration and administered the oral medications. ULP-F removed the gloves, put on a new pair of gloves, and placed R11's hearing aides. ULP-F removed the gloves, and left the room. ULP-F did not use hand sanitizer or wash her hands after glove removal. - at 7:31 a.m., ULP-F entered R12's room, put on gloves, set up and administered oral medications. ULP-F then removed eye drops from the drawer, held R12's upper eyelid while R12 held their lower eye lid, and administered eye drops into each eye. ULP-F then took out a iodine swab and a Band-Aid, removed R12's silicone toe separator, removed the old Band-Aid, swabbed R12's toe with the iodine swab, placed a clean Band-Aid, and put the toe separator back in place. ULP-F applied compression stockings on R12. ULP-F removed the gloves, and left the room. ULP-F did not use hand sanitizer or wash her hands after removing the gloves. - at 7:35 a.m., ULP-F entered R3's room, put on gloves, set up and administered oral medications. ULP-F set up Advair inhaler for administration, gave to R3 and she self administered. ULP-F then set up a nebulizer for R3 and placed the nebulizer mask on R3's face. ULP-F removed the gloves, and left the room. ULP-F did not use hand sanitizer or wash her hands after removing the gloves. - at 7:54 a.m., ULP-F entered R8's room, put on gloves, set up and administered oral	0 510		

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0 510	Continued From page 6 medications. ULP-F held R8's upper eye lid while R8 held her lower eye lid and ULP-F administered eye drops into both eyes. ULP-F handed R8 her nasal spray and R8 self administered. R8 laid down on her bed, ULP-F retrieved a wet washcloth with soap on it and dry washcloth from the bathroom. ULP-F washed and dried abdominal and groin folds and applied a medicated powder and placed a piece of cloth to the areas. ULP-F removed the gloves, and left the room. ULP-F did not use hand sanitizer or wash her hands after removing the gloves. - at 8:05 a.m., ULP-F responded to R2's call light, entered his room, helped him get a drink of water. ULP-F put on gloves and retrieved a basin from the bathroom cupboard which contained a urine collection leg bag, graduate, and a large syringe. The leg bag had clear fluid in it and ULP-F emptied the fluid into the toilet. ULP-F returned to R2's bedroom and placed the basin next to the bed. R2 was having difficulty sitting up on the edge of the bed, ULP-F got onto the bed on her knees and assisted R2 into a sitting position and then got off the bed. ULP-F changed the bed bag to a leg bag, fastened it to R2's leg, and placed the bed bag with urine in the basin. ULP-F then retrieved a wet wipe from the bathroom, and plugged in R2's phone per his request. ULP-F removed gloves and placed clean gloves. ULP-F assisted R2 to change boxer briefs, put on socks, brought R2 deodorant and nasal spray from the bathroom and gave to R2. R2 self administered and ULP-F returned the items to the bathroom. ULP-F then assisted R2 to button his shirt. R2 requested ULP-F put Biofreeze on his neck and ULP-F did as he requested. R2 stated he had to go to the bathroom; therefore, ULP-F placed the basin with the catheter supplies back in the cupboard to	0 510		

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0 510	Continued From page 7 clean later, removed gloves and left the room. ULP-F did not use hand sanitizer or wash her hands after removing the gloves. - at approximately 8:35 a.m., ULP-F answered R3's pendent alert. R3 complained of chest pain and need to use the bathroom. ULP-F requested a nurse and another ULP to assist her. ULP-F and ULP-E assisted R3 to the bathroom under supervision of the RN. ULP-F put on gloves, changed R3's incontinent brief, and assisted her back to the recliner. ULP-F administered oral medications at 9:04 a.m. ULP-F removed garbage, removed gloves and exited the apartment. ULP-F did not use hand sanitizer or wash her hands. - at 9:07 a.m., ULP-F returned to R2's room and put on gloves. ULP-F emptied the bed bag into the toilet. ULP-F put some tap water in the graduate, drew it up with a syringe, rinsed and emptied the bag. ULP-F put some more water and vinegar into the graduate, drew it up with a syringe, rinsed and emptied the bag, drew up some more, and put it into the bag, placed the bag back in the basin. ULP-F emptied what was left in the graduate back into the vinegar jug, and placed everything back in the cupboard. ULP-F then removed gloves and left the room. ULP-F did not use hand sanitizer or wash her hands. On August 13, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated staff were to wash hands or use hand sanitizer between residents and whenever personal cares are being completed, staff should have washed their hands. The licensee's 8.09 Hand washing policy dated February 25, 2025, indicated the following: Proper hand washing techniques should be used	0 510		

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0 510	Continued From page 8 to protect the spread of infection. Hand washing shall be completed: · Before, during, and after preparing food · Before eating food · Before and after caring for someone who is sick · Before and after treating a cut or wound · After using the toilet · After changing diapers or cleaning up after someone who has used the toilet · After blowing your nose, coughing, or sneezing · After touching an animal or animal waste · After handling pet food or pet treats · After touching garbage PROCEDURE: Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. There is no limit to the number of times you use ABHS before you must use soap and water. A good rule of thumb though, is to wash with soap and water when	0 510		

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0 510	Continued From page 9 hands are visibly soiled, after completing cares for someone with c. diff or norovirus, and when the hands have a "filmy" feel to them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 640		

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MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

(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
0 640	Continued From page 10 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 11:20 a.m., the surveyor observed a telephone in the dining room and at the front desk. There were no postings of the 911 emergency number in common areas and near the the telephones provided by the assisted living facility. On August 11, 2025, at 11:20 a.m., licensed assisted living director (LALD)-A stated she was unaware it was required to be posted by all facility provided telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and	0 650		

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0 650	Continued From page 11 competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained annual performance reviews that identify areas of improvement needed and training needs for two of two employees (unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on January 12, 2024, and provided direct care services to the residents.	0 650		

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0 650	Continued From page 12 On August 11, 2025, at 11:33 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record lacked evidence of an annual performance evaluation. ULP-F ULP-F was hired on January 9, 2024, and provided direct care services to the residents. On August 12, 2025, at 7:20 a.m., the surveyor observed ULP-F administering medications and completing cares to the residents. ULP-F's employee record lacked evidence of an annual performance evaluation. On August 14, 2025, at 1:34 p.m. clinical nurse supervisor (CNS)-B stated she had not completed annual performance evaluations for the employees. The licensee's 4.15 Employee Evaluation dated August 1, 2021, indicated all staff of [licensee] will be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on August 12, 2025, from 9:32 a.m. through 11:10 a.m., with director of maintenance (DM)-G, the surveyor observed one hour fire rated doors that did not self-close and latch in the first and second floor laundry rooms and the first and second floor trash rooms. The doors were equipped with door closers but were held open with toe kick devices. DM-G attempted to close the doors but the doors hit the door frame and would not fully close. DM-G stated they would adjust the doors and remove the toe-kick device. State Fire Code in MN Rules, chapter 7511 requires fire rated doors to be maintained to self-close and latch as designed. DM-G verified the above findings while accompanying on the tour and stated they	0 775		

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0 775	Continued From page 14 understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 15 Based on observation and interview, the licensee failed to provide smoke alarms inside resident sleeping rooms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on August 12, 2025, from 9:32 a.m. through 11:10 a.m., with director of maintenance (DM)-G, the surveyor observed that a smoke alarm was not provided in resident room 203 in the south wing. DM-G stated that all resident rooms in the south wing were the same and that smoke alarms were not provided in any of them. During same tour the surveyor observed that a smoke alarm was not provided in the sleeping room of resident room 112 in the "apartments". DM-G stated that all the resident rooms in what the facility calls the apartments were the same and that none of the sleeping rooms had smoke alarms. Smoke alarms are required to be installed inside all sleeping rooms. All required smoke alarms must be interconnected so activation of one alarm activates all alarms throughout the resident unit.	0 780		

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0 780	Continued From page 16 DM-G verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for four of four employees (unlicensed personnel (ULP)-H, ULP-I, activity director (AD)-J, and dietary aide (DA)-K. This resulted in an immediate correction order on	01290		

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01290	Continued From page 17 August 12, 2025. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-H ULP-H was hired on June 5, 2013, to provide direct care to the residents, and began providing direct care services under the Assisted Living Facility (ALF) license on August 1, 2021. ULP-H was not listed on the facility's NETStudy roster provided by the licensee. On August 12, 2025, at 6:45 a.m. ULP-H stated she had worked overnight and had passed medications to the residents while the other staff member passed medications to other residents, and they took turns to assure someone was at the front desk to let the surveyor into the building. R2's Medication Administration Summary (MAR) dated August 1-12, 2025, indicated ULP-H had administered medications to R2 on August 1, 5, 8, and 12, 2025. The licensee's staff schedule for August 3, 2025, through August 12, 2024, indicated ULP-H worked the overnight shift 11:00 p.m. until 7:30 a.m. on August 4, 5, 6, 7, and 11, 2025.	01290		

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01290	Continued From page 18 ULP-H was listed on DHS NETStudy 2.0 as "affiliated" on May 24, 2013, with HFID 887 (a nursing home previously ran by the same company, which closed), and had a separation date of December 18, 2021. ULP-F did not have a current, cleared background study in affiliation with the licensee. ULP-I ULP-I was hired on April 13, 2021, and began providing direct care services to the residents under the ALF license on August 1, 2021. ULP-I was not listed on the facility's NETStudy roster provided by the licensee. R2's MAR dated August 1-12, 2025, indicated ULP-I had administered medications to R2 on August 2 and 4, 2025. The licensee's staff schedule for August 3, 2025, through August 12, 2025, indicated ULP-I worked August 4, 2025. ULP-I was listed on DHS NETStudy 2.0 as "affiliated" on April 1, 2021, with HFID 887 and had a separation date of December 18, 2021. ULP-F did not have a current, cleared background study in affiliation with the licensee. AD-J AD-J was hired on September 6, 1985, and began providing activity services under the ALF license on August 1, 2021. AD-J was not listed on the facility's NETStudy roster provided by the licensee.	01290		

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01290	Continued From page 19 On August 11, 2025, through August 12, 2025, the surveyor observed AD-J within the facility unsupervised, visiting with residents, and completing activities with the residents. On August 12, 2025, at 2:34 p.m., licensed assisted living director (LALD)-A stated AD-J typically worked Monday, Tuesday, and Thursday 8:00 a.m. to 4:30 p.m. AD-J was listed on DHS NETStudy 2.0 as "affiliated" on September 11, 1996, with HFID 887 and had a separation date of December 18, 2021. AD-J did not have a current, cleared background study in affiliation with the licensee. DA-K DA-K was hired on July 6, 1998, and began providing meal service under the ALF license on August 1, 2021. DA-K was not listed on the facility's NETStudy roster provided by the licensee. DA-K was listed on DHS NETStudy 2.0 as "affiliated" on January 18, 2000, with HFID 887 and had a separation date of December 18, 2021. ULP-F did not have a current, cleared background study in affiliation with the licensee. On August 12, 2025, at 12:57 p.m., clinical nurse supervisor (CNS)-B stated ULP-H and ULP-I both worked unsupervised providing direct cares to residents within the facility. On August 12, 2025, at 2:34 p.m., LALD-A stated all staff should have a background study completed.	01290		

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01290	Continued From page 20 The licensee's 4.02 Background Studies policy dated August 30, 2022, indicated a background study would be completed on all employees, volunteers and contractors. "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On August 12, 2025, the licensee put interventions into place to mitigate the immediate risk to residents. The scope and level remains at I.	01290		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors 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; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5),	01530		

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01530	Continued From page 21 and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a 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 the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; 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)-E, ULP-F) received the required amount of dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01530		

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01530	Continued From page 22 a large portion or all of the residents). The findings include: The facility was licensed as an Assisted Living Facility. ULP-E ULP-E was hired on January 12, 2024, and provided direct care services. On August 11, 2025, at 11:33 a.m. the surveyor observed ULP-E administering medications to the residents. ULP-E's employee file included four hours of online dementia training completed. ULP-F ULP-F was hired on January 9, 2024, and provided direct care services. On August 12, 2025, at 7:20 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee file included four hours of online dementia training completed. On August 14, 2025, at 1:34 p.m., clinical nurse supervisor (CNS)-B stated her understanding was the staff were to have four hours dementia training within 160 hours. CNS-B further stated ULP-E and ULP-F both would have worked more than 160 hours No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01530		

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01530	Continued From page 23 (21) days	01530		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plan modifications were completed and signed when the resident's services changed for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 24 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the facility and began receiving services on March 10, 2025. On August 12, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-F assisting R2 with grooming, dressing, and changing the urinary catheter collection bed bag to a leg bag. R2's Service Recap Summary dated August 2024, indicated R2's services included catheter care, bathing, escorts, bed making, housekeeping, laundry, meals, safety check, and medication administration. R2's Master Care Plan dated June 19, 2025, indicated R2's services included - bathing; - dressing -occasionally requests assist related to catheter; - shaving assistance; - assistance with incontinence care and catheter care - empty and change bed bag and leg bag; and - medication management and administration. R2's signed service plan signed March 10, 2025, indicated R2's services included medication	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30459	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

(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
01640	Continued From page 25 administration, housekeeping, laundry, "I'm OK" checks, assistance with bathing and stand by assistance as needed, and service level 4 was identified. Attached was a signed addendum dated July 5, 2025, which indicated a change in services to level 8 and the cost for the package. R2's service plan did not include assistance with catheter cares, and dressing assistance. The licensee's undated, Level of Services document indicated the following: - service level 4 included the cost of the package and "casemix A": - "AL (assisted living) Aide assistance with ADLs (activities of daily living), weekly housekeeping, laundry & linen changes. - Medication administration. - RN/LPN care/case management." - service level 8 included the cost of the package "custom TBD (to be determined)" and "casemix H, I, J": - "AL Aide assistance with ADLs, weekly housekeeping, laundry & linen changes. - Medication administration. - RN/LPN care/case management" The document indicated the exact same services for levels 3-8 with different case mix and prices. R3 R3 was admitted to the facility and began receiving services on November 8, 2023. On August 12, 2025, at 7:35 a.m., the surveyor observed ULP-F administering medications to R3. ULP-F asked R3 to remove her oxygen so she could put on her nebulizer treatment mask. ULP-F stated that she does not do anything with R3's oxygen, and R3 is independent with oxygen use.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30459	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

(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
01640	Continued From page 26 On August 12, 2025, at approximately 8:30 a.m., ULP-F returned to R3's room. The surveyor observed R3 did not have her oxygen in place and the nebulizer was shut off. ULP-F and ULP-E were observed physically assisting R3 to stand, ambulate to the bathroom, assist with clothing and onto the toilet. At 8:45 a.m., ULP-F assisted to change incontinent brief, and the ULPs assisted R3 back to her recliner. Registered nurse (RN)-C assessed R3 and stated her oxygen saturation was 68-78% on room air. RN-C stated R3 was on hospice. At 9:00 a.m., R3's oxygen was put back on at 4 L (liters) per nasal cannula. The surveyor observed R3 had bilateral lower legs wrapped. RN-C stated wound care had already been completed. R3's Service Recap Summary dated August 2025, indicated R3's services included wound care, toileting, mobility assistance, respiratory equipment assistance, bathing, housekeeping laundry, meals, medication management and medication administration. R3's Master Care Plan dated July 28, 2025, indicated R3's services included bathing, dressing, grooming, stand by assistance with transfers and ambulation, assistance with bed mobility, assistance with incontinent products and toileting, assistance with nebulizers set up with self-administration, hospice "started today", medication management and administration, and wound care. R3's service plan dated November 8, 2023, indicated R3's services included medication management and administration, bathing assistance, housekeeping, laundry "I'm OK"	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

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01640	Continued From page 27 checks, and medication set-up. The service plan indicated R3's service level was elderly waiver with cost of services per "county". R3's service plan did not include wound care, oxygen use, transfer, ambulation, or toileting assistance. On August 14, 2025, at 1:34 p.m., clinical nurse supervisor (CNS)-B stated the service plan refers to the level of service with the details listed in the care plan. The licensee does not supply the care plan to the resident or responsible party. When R3 was admitted to hospice, the facility completed a new assessment and updated the care plan to reflect the increase in needs, but they did not sign a new service plan. R2 had a fluctuation in care needs and had an increase in services including the catheter cares and the modification was signed. The services are the same on all levels 3-8 but the actual cares being provided were on the care plan. The licensee's Service Plan policy dated December 2024, indicated a service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30459	A. BUILDING: _____ B. WING _____	08/14/2025

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MINNEOTA ASSISTED LIVING AND HOME HEA	700 NORTH MADISON STREET MINNEOTA, MN 56264

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01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the open date and/or expiration date for one of four residents (R3) with time sensitive medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 12, 2025, at 7:35 a.m., the surveyor observed R3's locked medication drawer with unlicensed personnel (ULP)-F. The following medications were observed: - Ventolin HFA inhaler open and in use - there was no open date or expiration date on the inhaler or the box. - Advair inhaler open and in use - there was no open date or expiration date on the inhaler or the box.	01890		

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
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01890	Continued From page 29 On August 13, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated all time sensitive medications should be labeled when they are opened and when they expire, and staff would go by the manufacturer expiration date. Advair's prescribing information dated April 2008, indicated the device should be discarded 1 month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads "0"), whichever comes first. Ventolin's prescribing information dated December 2014, identified the inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever 455 comes first. The licensee's Medication Storage policy dated January 2025, indicated medications would be stored consistent with manufacturer instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	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	01910		

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01910	Continued From page 30 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, 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 include all required information on the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's record included a Discharge/Transfer Summary printed August 11, 2025, indicated R1 was admitted to the hospital on April 29, 2025, and was subsequently admitted to a nursing home on May 7, 2025.	01910		

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01910	Continued From page 31 R1's Medication Disposition dated May 7, 2025, indicated registered nurse (RN)-C had destroyed R1's two controlled medications. R1's record lacked documentation of the disposition of the rest of R1's medications including the medication's 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 11, 2025, at 2:06 p.m., RN-C stated the rest of R1's medications were returned to the pharmacy. There was no documentation regarding the medications. RN-C stated she was unaware she needed to document disposition of medications returned to the pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 32 (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 include a written statement of the treatment on the service plan for two of two residents (R2, 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 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:	01940		

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01940	Continued From page 33 R2 R2 was admitted to the facility and began receiving services on March 10, 2025. On August 12, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-F assisting R2 with grooming, dressing, and changing the urinary catheter collection bed bag to a leg bag. R2's Service Recap Summary dated August 2024, indicated R2's services included catheter care, bathing, escorts, bed making, housekeeping, laundry, meals, safety check, and medication administration. R2's Master Care Plan dated June 19, 2025, indicated R2's services included - bathing; - dressing -occasionally requests assist related to catheter; - shaving assistance; - assistance with incontinence care and catheter care - empty and change bed bag and leg bag; and - medication management and administration. R2's physician order dated June 3, 2025, included an order to change the catheter monthly and irrigate the catheter as needed. R2's signed service plan signed March 10, 2025, indicated R2's services included medication administration, house keeping, laundry, "I'm OK" checks, assistance with bathing and stand by assistance as needed, and service level 4 was identified. Attached was a signed addendum dated July 5, 2025, which indicated a change in services to level 8 and the cost for the package. R2's service plan did not include the treatment of	01940		

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01940	Continued From page 34 catheter change. The licensee's undated, Level of Services document indicated the following: - service level 4 included the cost of the package and "casemix A": - "AL (assisted living) Aide assistance with ADL's (activities of daily living), weekly housekeeping, laundry & linen changes. - Medication administration. - RN/LPN care/case management." - service level 8 included the cost of the package "custom TBD (to be determined)" and "casemix H, I, J": - "AL Aide assistance with ADL's, weekly housekeeping, laundry & linen changes. - Medication administration. - RN/LPN care/case management" The document indicated the exact same services for levels 3-8 with different case mix and prices. R3 R3 was admitted to the facility and began receiving services on November 8, 2023. On August 12, 2025, at 7:35 a.m., the surveyor observed ULP-F administering medications to R3. ULP-F asked R3 to remove her oxygen so she could put on her nebulizer treatment mask. ULP-F stated R3 is independent with her oxygen use. On August 12, 2025, at approximately 8:30 a.m., ULP-F returned to R3's room. The surveyor observed R3 did not have her oxygen in place and the nebulizer was shut off. ULP-F and ULP-E were observed physically assisting R3 to stand, ambulate to the bathroom, assist with clothing and onto the toilet. At 8:45 a.m., ULP-F assisted	01940		

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01940	Continued From page 35 to change R3's incontinent brief, and then back to her recliner. Registered nurse (RN)-C assessed R3 and stated her oxygen saturation was 68-78% on room air. RN-C stated R3 was on hospice. At 9:00 a.m., R3's oxygen was put back on at 4 L (liters) per nasal cannula. The surveyor observed R3 had bilateral lower legs wrapped. RN-C stated wound care had already been completed. R3's Service Recap Summary dated August 2025, indicated R3's services included wound care, toileting, mobility assistance, respiratory equipment assistance, bathing, housekeeping laundry, meals, medication management and medication administration. R3's Master Care Plan dated July 28, 2025, indicated R3's services included bathing, dressing, grooming, stand by assistance with transfers and ambulation, assistance with bed mobility, assistance with incontinent products and toileting, assistance with nebulizers set up with self administration, hospice "started today", medication management and administration, and wound care. R3's hospice orders dated July 11, 2025, included Oxygen - May implement home oxygen 1-5 L per nasal cannula as needed tor comfort - intermittent or continuous. R3's physician orders dated July 15, 2025, included wound care daily. R3's service plan dated November 8, 2023, indicated R3's services included medication management and administration, bathing assistance, housekeeping, laundry "I'm OK" checks, and medication set-up. The service plan	01940		

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01940	Continued From page 36 indicated R3's service level was elderly waiver with cost of services per "county". R3's service plan did not include wound care, oxygen use, transfer, ambulation, or toileting assistance. On August 14, 2025, at 1:34 p.m., clinical nurse supervisor (CNS)-B stated the service plan refers to the level of service with the details listed in the care plan. The licensee does not supply the care plan to the resident or responsible party. R2 had a fluctuation in care needs and had an increase in services including the catheter, which the registered nurse changes monthly and the modification was signed. When R3 was admitted to hospice, the licensee completed a new assessment and updated the care plan to reflect the increase in needs but did not sign a new service plan. The services are the same on all levels 3-8 but the actual cares being provided are on the care plan. The licensee's Treatment and Therapy Management Plan policy dated December 2024, indicated "the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

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

Food & Beverage Inspection Report

Establishment Info

Minneota Assisted Living
700 North Madison Street
Minneota, MN 56264
Lyon County
Parcel:

Phone:

License Info

License: HFID 30459

Risk:
License:
Expires on:
CFPM: Andre R. Dionne
CFPM #: 105533; Exp: 2/3/2027

Inspection Info

Report Number: F7990251012
Inspection Type: Full - Single
Date: 8/12/2025 Time: 11:10:21 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F7990251012 from 8/12/2025

Benjamin D. Ische

Andre Dionne
Kitchen Manager

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Minneota Assisted Living
Minneota
County/Group: Lyon County

Inspection Info

Report Number: F7990251012
Inspection Type: Full
Date: 8/12/2025
Time: 11:10:21 AM

New Record: Product/Item/Unit: Tomato **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Casserole**; Temperature Process:** Cooking
Location: Oven at 180 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Minneota Assisted Living
Minneota
County/Group: Lyon County

Inspection Info

Report Number: F7990251012
Inspection Type: Full
Date: 8/12/2025
Time: 11:10:21 AM

New Record: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To**
Comment: 100 PPM Chlorine
Violation Issued?: No

New Record: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To**
Comment: 700 PPM
Violation Issued?: No