Electronically Delivered

October 30, 2025

Licensee
Traditions of Montgomery LLC
399 Lexington Avenue Northwest
Montgomery, MN 56069

RE: Project Number(s) SL30730016

Dear Licensee:

On September 9, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 22, 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,

Carrie Euerle, Supervisor
State Rapid Response Team
Email: Carrie.Euerle@state.mn.us
Telephone: 651-242-8846 Fax: 1-800-337-9238

HHH

Electronically Delivered

July 25, 2025

Licensee
Traditions of Montgomery LLC
399 Lexington Avenue Northwest
Montgomery, MN 56069

RE: Project Number(s) SL30730016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 22, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

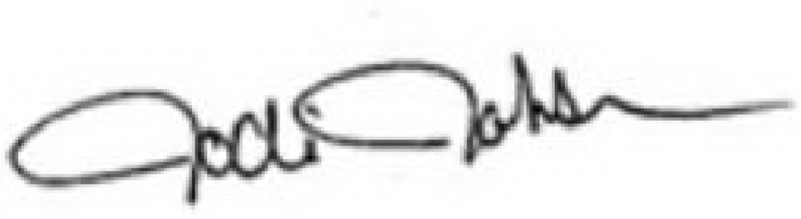
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30730	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MONTGOMERY LLC	399 LEXINGTON AVENUE NW MONTGOMERY, MN 56069

(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: SL30730016-0 On May 19, 2025 through May 22, 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 38 residents; 38 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate order was issued on May 20, 2025, at a level 3, Widespread (I). The licensee took action on May 20, 2025; 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 4 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's TB risk assessment dated January 12, 2025, indicated the licensee was a low risk. ULP-C was hired on December 23, 2024, to provide direct care services to residents of the facility. ULP-C's employee's record contained a first-step TST administered December 27, 2024, and read on December 29, 2024. ULP-E's employee record lacked evidence any other TB screening had been completed. On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated ULP-E's second step TST had not been completed as required. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see	0 660		

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0 660	Continued From page 5 whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated: 3. b. Prior to contact with clients, each staff person will be screened for TB. A two-step skin test or single interferon gamma release Assay (IGRA) for M. tuberculosis will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	0 690		

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0 690	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry 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 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's Initial unified Assessment and On-Admit Unified Assessment were not dated or authenticated with the title of the person completing the assessment. On May 20, 2025, at 10:13 a.m., clinical nurse supervisor (CNS)-B reviewed R3's initial and on-admit assessments and stated they had not been dated or authenticated and stated, "That's on me". CNS-B stated she was able to see in the electronic record when the assessments had been "locked," although did not date or authenticate the actual assessments. The licensee's Resident Records policy dated May 27, 2022, indicated: 1. Record entries will be legible, permanently recorded, dated, and signed by the person making the entry.	0 690		

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0 690	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
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 keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and 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 potential to affect a large portion or all of the residents). Findings include: On facility tour with the maintenance manager (MM)-E on May 21, 2025, between 8:00 a.m. and 10:30 a.m. the following deficient conditions were observed: SMOKE ALARMS:	0 775		

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0 775	Continued From page 8 The surveyor observed that there were smoke alarms throughout the facility over 10 years old from date of manufacture. All smoke alarms over 10 years old from date of manufacture shall be replaced with like type powered alarms. All resident rooms shall be checked. EXIT/EMERGENCY LIGHTS: The surveyor observed that there were several exit/emergency lights in the facility that failed to operate when push button tested or were very weak. All emergency/exit lights shall be push button tested monthly and the annual 30 minute test completed. This must be documented. Any defective lights shall be fixed in a timely manner. FIRE SPRINKLER SYSTEM: The surveyor observed there were listed deficiencies in the Brother's Fire annual fire sprinkler report. All noted deficiencies on the Brother's Fire annual report shall be fixed. LOCKING: The surveyor observed there was a not a switch/key in the dementia care wing that released all the doors. There shall be a key/switch that unlocks all the doors in the dementia care wing. CARBON MONOXIDE:	0 775		

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0 775	Continued From page 9 The surveyor observed that there were carbon monoxide missing in some resident rooms. Carbon monoxide protection shall be provided as required by the Minnesota State Fire Code. All resident rooms shall be checked. The deficient conditions were visually verified by the MM-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 10 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation when the resident had not returned to the facility within four days for one of one resident (R3) who was hospitalized. 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).	01060		

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TRADITIONS OF MONTGOMERY LLC	399 LEXINGTON AVENUE NW MONTGOMERY, MN 56069

(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
01060	Continued From page 11 The findings include: R3's diagnoses included age-related cognitive decline, type two diabetes mellitus, congestive heart failure, and repeated falls. R3's Individualized Service Plan dated September 30, 2024, indicated R3 received services including bathing, dressing, grooming, toileting, transfers, escorts to and from meals, behavior monitoring, housekeeping, laundry, and medication administration. R3's progress notes dated May 1, 2025, indicated staff reported R3 was unwell with a fever, sweaty, and not cooperating with transfers. EMTs (emergency medical technicians) were called and R3 was transferred to the hospital for further evaluation via ambulance. R3's family member called later that day and stated R3 would be admitted to the hospital and was diagnosed with a UTI (urinary tract infection). R3's progress notes further indicated R3 returned to the licensee on May 8, 2025 (seven days later). R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 12 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked evidence of notification to OOLTC when they were hospitalized more than four days. On May 21, 2025, at 2:45 p.m., licensed assisted living director (LALD)-A stated they usually fax a written notice related to emergency relocation to the ombudsman, although not to the resident or resident representative, and was unaware of the requirement. LALD-A further stated she could not locate evidence a written notice had been provided to the ombudsman for R3's hospitalization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01370		

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01370	Continued From page 13 devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-C, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01370		

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01370	Continued From page 14 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired December 23, 2024, to provide direct care services. On May 20, 2025, at 7:25 a.m., the surveyor observed ULP-C assisting the hospice aide with changing R3's brief, providing peri-care, and re-positioning. ULP-C's record lacked evidence the following competencies had been completed prior to providing direct cares: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing care of teeth, gums, and oral prosthetic devices care and use of hearing aids dressing and assisting with toileting; and - standby assistance techniques and how to perform them ULP-F ULP-F was hired October 17, 2023, to provide direct care services. ULP-F's record lacked evidence the following competencies had been completed prior to providing direct cares: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing care of teeth, gums, and oral prosthetic devices care and use of hearing aids dressing and assisting with toileting	01370		

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01370	Continued From page 15 On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated she had provided training to ULP-C and observed her completing cares, transfers and ambulation, although she could not locate any signed competencies. CNS-B further stated ULP-C had completed the above online trainings and also was experienced as had worked at another assisted living facility prior to hire. CNS-B reviewed ULP-F's employee record and was unable to locate evidence of competencies for the above activities of daily living (ADLs). The licensee's Assisted Living Orientation - ULP Staff policy revised May 27, 2022, indicated: 5. In addition to training all staff receive, ULPs who are e not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration: a. Hair care b. Bathing c. Care of teeth, gums, and oral prosthetic devices d. Care and use of hearing aids e. Dressing f. Assisting with toileting g. Standby assistance techniques 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 16 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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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-C was hired December 23, 2024, to provide direct care services. On May 20, 2025, at 7:25 a.m., the surveyor	01380		

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01380	Continued From page 17 observed ULP-C assisting the hospice aide with changing R3's brief, providing peri-care, and re-positioning. On May 20, 2025, at 7:58 a.m., the surveyor observed ULP-C and ULP-D transferring R5 from bed to a wheelchair. ULP-C's record lacked evidence the following competencies had been completed prior to providing direct cares: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motion and positioning On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated she had provided training to ULP-C and observed her doing cares, transfers and ambulation, although could not locate any signed competencies. CNS-B further stated ULP-C had completed the above online trainings and also was experienced as had worked at another assisted living facility prior to hire. The licensee's Assisted Living Orientation - ULP Staff policy revised May 27, 2022, indicated: 5. In addition to training all staff receive, ULPs who are e not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration: k. Reading and Recording temperature, pulse and respirations of the resident l. Safe transfers and ambulation m. Range of motion n. positioning No further information was provided.	01380		

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01380	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of one of one newly hired unlicensed personnel (ULP-C) performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for	01440		

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01440	Continued From page 19 the licensee. 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-C was hired December 23, 2024, to provide direct care services. On May 20, 2025, at 7:16 a.m., the surveyor observed ULP-C administering medications to R4. ULP-C's employee record included an undated, 30 Day Employee Progress Report signed by clinical nurse supervisor (CNS)-B. The report did not include supervision of a delegated task. On May 21, 2025, at 2:45 p.m., CNS-B stated ULP-C's employee record did not include supervision of a delegated task. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 20 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for two of two residents (R2, R3) and failed to complete a change of condition assessment timely for one of one resident (R3) when admitted to hospice 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	01620		

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01620	Continued From page 21 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 R2 began receiving services on February 12, 2025, with diagnoses including congestive heart failure, atrial fibrillation, and history of falling. R2's Individualized Service Plan dated February 10, 2025, indicated R2 received services including bathing, dressing, grooming, toileting, transfers, housekeeping, laundry, and medication administration. R2's 14 Day Unified Assessment dated March 18, 2025, was completed 34 days after the start of services, thus exceeding 14 days. R3 R3 began receiving services on September 30, 2024, with diagnoses including age-related cognitive decline, type two diabetes mellitus, congestive heart failure, and repeated falls. R3's Individualized Service Plan dated September 30, 2024, indicated R3 received services including bathing, dressing, grooming, toileting, transfers, escorts to and from meals, behavior monitoring, housekeeping, laundry, and medication administration. R3's 14 Day Unified Assessment dated October 25, 2024, was completed 25 days after the start of services, thus exceeding 14 days. R3 was admitted to hospice services on May 16, 2025; however, R3's record did not include a	01620		

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01620	Continued From page 22 change of condition assessment with initiation of hospice services. On May 20, 2025, at 10:13 a.m., clinical nurse supervisor reviewed R2 and R3's 14-day assessments and stated they were completed late. CNS-C further stated she was "working on" R3's change of condition assessment, although she had not completed it yet. The licensee's Initial and On-Going Nursing Assessment of Residents policy revised May 27, 2022, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition 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 23 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 three 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 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 R2's diagnoses included obstructive sleep apnea. R2's provider orders dated February 21, 2025,	01640		

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01640	Continued From page 24 included use of a CPAP (continuous positive airway pressure) machine. R2's ADL (activities of daily living) Flowsheet dated May 2025, included: Assist resident with CPAP as needed. On May 20, 2025, at 11:30 a.m., the surveyor observed a CPAP machine with attached mask, on R2's bedside table. R2 stated staff assisted him with applying the mask at bedtime. R2's Individualized Service Plan dated February 10, 2025, did not include assistance with the CPAP machine. On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated R2's CPAP machine use was included on the current assessment, but it was not on the service plan. R3 R3's diagnoses included age-related cognitive decline, type two diabetes mellitus, congestive heart failure, and repeated falls. R3's progress notes dated May 1, 2025, indicated staff reported R3 was unwell with a fever, sweaty, and not cooperating with transfers. EMTs (emergency medical technicians) were called and R3 was transferred to the hospital for further evaluation via ambulance. R3's family member called later that day and stated R3 would be admitted to the hospital and was diagnosed with a UTI (urinary tract infection). R3's progress notes further indicated R3 returned to the licensee on May 8, 2025. The progress notes indicated R3 showed a decline over the next seven days due to increased weakness, requiring staff to utilize an EZ stand for transfers and feeding R3, who	01640		

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01640	Continued From page 25 was previously independent with eating. R3 was admitted to hospice services on May 16, 2025. On May 20, 2025, at 7:25 a.m., the surveyor observed ULP-C assisting the hospice aide with changing R3's brief, providing peri-care, and re-positioning. On May 20, 2025, at 7:48 a.m., ULP-C stated R3 was a two-person assist with the full lift with transfers. ULP-C further stated R3 had declined significantly upon return from the hospital and required more assistance with services. R3's Individualized Service Plan dated September 30, 2024, indicated R3 received services including bathing, dressing, grooming, toileting, transfer, escorts to and from meals, behavior monitoring, housekeeping, laundry, and medication administration. The service plan also indicated R3 required assist of one staff with all ADLs listed above. R3's service plan had not been revised upon return from hospitalization and the initiation of hospice services. On May 20, 2025, at 10:13 a.m., CNS-B stated R3's service plan had not been updated upon return from the hospital and the initiation of hospice services. The licensee's Contents of Service Plans policy revised May 27, 2022, indicated: All assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN (registered nurse) and/or other licensed health professional. 3. Service plans and any revisions to service plans will have a signature or other authentication	01640		

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01640	Continued From page 26 by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. 4. Service plans are reviewed and revised as needed based upon on-going resident assessment. 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 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 one of two unlicensed personnel (ULP-C) employee records contained training and competency evaluations for medication administration by a registered nurse (RN).	01750		

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01750	Continued From page 27 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-C was hired December 23, 2024, to provide direct care services. On May 20, 2025, at 7:16 a.m., the surveyor observed ULP-C setting up and administering insulin to R4. On May 20, 2025, at 8:18 a.m., the surveyor observed ULP-C was observed setting up (including crushing) and administering oral medications to R5. ULP-C's record lacked evidence of competency testing for medication administration for all routes prior to administering medications independently. On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated she had provided training to ULP-C and observed her setting up and administering medications, including insulin, although she could not locate any signed competencies. CNS-B further stated ULP-C had completed the above online trainings and also was experienced as had worked at another assisted living facility prior to hire. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy	01750		

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01750	Continued From page 28 Administration policy revised May 27, 2022, indicated: Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. 3. The RN will document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 29 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 (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the licensee's residents including assistance with oxygen, CPAP	01940		

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01940	Continued From page 30 (continuous positive airway pressure) machines, and compression stockings. R2 R2's diagnoses included obstructive sleep apnea. R2's provider orders dated February 21, 2025, included use of a CPAP (continuous positive airway pressure) machine. R2's ADL (activities of daily living) Flowsheet dated May 2025, included: Assist resident with CPAP as needed. On May 20, 2025, at 11:30 a.m., the surveyor observed a CPAP machine with attached mask, on R2's bedside table. R2 stated staff assisted him with applying the mask at bedtime. R2's Individualized Service Plan dated February 10, 2025, did not include assistance with the CPAP machine. R4 R4's diagnoses included type II diabetes mellitus, chronic kidney disease, coronary artery disease, and localized edema (swelling). R4's provider orders dated February 5, 2024, included an order for anti-embolism stockings, put on 4-6 hours per day per patient comfort. R4's Individualized Service Plan dated December 10, 2025, indicated: Assist of One with TED (thrombo embolic deterrent) hose/compression stockings (used to increase circulation and decrease swelling in lower extremities). Put on in the morning, take off at night and hand wash/hang dry. Two times daily with AM and HS (hour of sleep) cares.	01940		

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01940	Continued From page 31 R4's ADL Flowsheet dated May 2025, included: Dressing Assistance: Partial Assist Staff assist as needed with lower body and apply TED (compression) stockings. R2 and R4's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On January 23, 2025, at 11:44 a.m., clinical nurse supervisor (CNS)-C reviewed R2 and R4's treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with R2's CPAP machine or R4's compression stockings. The licensees undated, Individualized Treatment and Therapy Management Plan form indicated: Our home care staff will provide ordered or prescribed treatment and therapy services. Your treatment and therapy management plan will be reviewed periodically and modified as needed. We have included a description of the treatment and therapy management service that will be provided below by our facility staff: (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 will be	01940		

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01940	Continued From page 32 current with specific resident instructions and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-C) demonstrated competency in blood glucose checks, oxygen, compression stockings, and CPAP (continuous positive airway pressure) machine to a registered	01950		

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01950	Continued From page 33 nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the licensee's residents. ULP-C was hired December 23, 2024, to provide direct care services. On May 20, 2025, at 7:16 a.m., the surveyor observed ULP-C setting up insulin for administration for R4. ULP-C stated she had previously tested R4's blood glucose resulting in a level of 285. ULP-C reviewed R4's sliding scale insulin order and stated she would be administering six units per the provider order. ULP-C's record lacked competencies for blood glucose checks, oxygen, compression stockings, and CPAP machine to a RN. On May 22, 2025, at 10:28 a.m., CNS-B stated she had provided training to ULP-C and observed her perform blood glucose testing, although did not have evidence of competency testing. CNS-B stated also did not have evidence of competency testing for oxygen, compression stockings, or	01950		

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01950	Continued From page 34 CPAP machine CNS-B further stated ULP-C had completed the above online trainings and also was experienced as had worked at another assisted living facility prior to hire. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy revised May 27, 2022, indicated: Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. 3. The RN will document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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	01960		

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01960	Continued From page 35 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 interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of three residents (R4). 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: R4's diagnoses included type II diabetes mellitus, chronic kidney disease, coronary artery disease, and localized edema (swelling). R4's provider orders dated February 5, 2024, included: - furosemide (diuretic/water pill) 40 milligrams, take 1/2 tablet by mouth daily as needed (PRN) for 3 lb (pound) weight gain in 24 hours - Daily weights. Notify provider for any weight gain of 3# (three pounds) or more in 24 hours. Use same scale each time. R4's medication administration record (MAR) dated May 2025, included the above PRN furosemide order, although it did not include daily weights. The MAR indicated staff were weighing	01960		

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01960	Continued From page 36 R4 weekly. On May 22, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated staff were now weighing R4 weekly instead of daily as R4 now received hospice services. R4 stated she would check with R4's provider to see if the daily weights and PRN furosemide were still needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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 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:	02170		

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02170	Continued From page 37 (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 interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R3, R4) who received services in the secured memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 held an assisted living with dementia care license effective July 1, 2024. R3	02170		

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02170	Continued From page 38 R3's diagnoses including age-related cognitive decline, type two diabetes mellitus, congestive heart failure, and repeated falls. R3's Individualized Service Plan dated September 30, 2024, indicated R3 received services including bathing, dressing, grooming, toileting, transfers, escorts to and from meals, behavior monitoring, housekeeping, laundry, and medication administration. The service plan also indicated R3 exhibited wandering on the unit. R3's undated, Social History and Interest Profile completed by R3's family member, indicated religious affiliation, previous occupation, activities enjoyed, and daily routine. R3's Return from Hospital Unified Assessment dated May 8, 2025, included preferred leisure activities and the need for reminders for activities happening each day. R3's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R3's record did not include evidence of an individualized activity plan based on R3's activity assessment. R4 R4's diagnoses included dementia, type II	02170		

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02170	Continued From page 39 diabetes mellitus, chronic kidney disease, coronary artery disease, and localized edema (swelling). R4's Individualized Service Plan dated December 10, 2025, indicated R4 received services including medication administration, housekeeping laundry, assistance with dressing, grooming, oral care, showering, toileting, cognitive deficit/behavior monitoring including redirection, cues, and prompts. R4's Client Information form completed by R4's family member dated May 15, 2023, included food preferences, daily routine, spiritual/religious preferences, preferred entertainment, and preferred exercise. R4's 90 Day Unified Assessment dated April 24, 2025, preferred leisure activities and the need for reminders for resident to attend activities. R4's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R4's record did not include evidence of an individualized activity plan based on R4's activity assessment. On May 20, 2025, at 8:37 a.m., licensed assisted living director (LALD)-A stated upon admission,	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30730	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MONTGOMERY LLC	399 LEXINGTON AVENUE NW MONTGOMERY, MN 56069

(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 40 residents are asked some questions related to activities and also have the resident or family member fill out an interest profile. LALD-A stated she was not aware of a specific form for the memory care residents that was individualized for activities. The licensee's Description of Life Enrichment Programs and how Activities are Implement in ALDC (assisted living dementia care) policy dated May 27, 2022, indicated: 1. Each resident receiving assisted living services will be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 2. To further facilitate person-centered care, social history information,information about the person's life history, will be gathered to assist in planning, information gathered may include information such as: a. places lived b. education, work, and military service history c. cultural and religious background d. family and other significant relationships 3. This information will be shared with staff as they are oriented to the individual. 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs.	02170		

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02170	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for three of three residents (R4, R5, R2) with a bed rail. This resulted in an immediate correction order on May 20, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 On May 20, 2025, at 7:16 a.m., the surveyor observed unlicensed personnel (ULP)-C	02310		

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	30730	A. BUILDING: _____ B. WING _____	05/22/2025

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02310	Continued From page 42 administering insulin to R4 in his apartment. R4's bed had a hospital bed rail in the raised position on the exit side of the head of the bed. R4's diagnoses included dementia, type II diabetes, and coronary artery disease. R4's Service Plan dated, December 10, 2024, indicated R4 received services including medication administration, assistance with dressing, grooming, oral care, showering, toileting/incontinence care, behavior monitoring, housekeeping, and laundry. R4's 90 Day Unified Assessment dated April 24, 2025, indicated R4 utilized a hospital bed provided by a hospice agency. The assessment did not identify or include an assessment of R4's bed rail. R4's record did not include evidence of a bed rail assessment. R5 On May 20, 2025, at 7:58 a.m., the surveyor observed ULP-C and ULP-D getting R5 up and out of bed for the day and providing morning cares. R5 was lying in bed under the covers with a hospital bed rail in the raised position on the exit side of the head of the bed. ULP-C and ULP-D assisted R5 to a seated position prior to transferring her into a wheelchair. R5 did not attempt to utilize the bed rail during the observation. R5's diagnoses included dementia, chronic kidney disease, and history of falling. R5's Service Plan dated September 20, 2024, indicated services included medication	02310		

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	30730	A. BUILDING: _____ B. WING _____	05/22/2025

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02310	Continued From page 43 administration, assistance with dressing, grooming, oral care, bathing, toileting, transfers, escorts to meals and activities, behavior monitoring, housekeeping, and laundry. R5's 90 Day Unified Assessment dated April 10, 2025, indicated R5 had a hospital bed provided by hospice. The assessment did not identify or include an assessment of R5's bed rail. R5's record did not include evidence of a bed rail assessment. R2 During an interview on May 20, 2025, at 11:30 a.m., R2 stated he utilized a bed rail to assist with positioning. With R2's permission, the surveyor observed R2's bed which had bilateral hospital bed rails in the raised position at the head of the bed. R2 was admitted to the licensee on February 12, 2025, with diagnoses including, macular degeneration, atrial fibrillation, and history of falling. R2's Service Plan dated February 10, 2025, indicated R2 received services including medication administration, assistance with dressing, grooming, toileting, transfers, showering, escorts to and from meals and activities, housekeeping, and laundry. R2's 14 Day Unified Assessment dated March 18, 2025, indicated R2 utilized a hospital bed. The assessment did not identify or include an assessment of R2's bed rails. R2's record did not include evidence of a bed rail assessment.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30730	A. BUILDING: _____ B. WING _____	05/22/2025

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02310	Continued From page 44 On May 20, 2025, at 1:29 p.m., clinical nurse supervisor (CNS)-B stated they were unaware of the need to conduct a bed rail assessment when hospice provided the beds including the attached bed rails. CNS-B further stated though R4 and R5 received hospice services, R2 did not. The licensee's Bedrail Devices and Device Assessment policy reviewed February 1, 2025, indicated: 1. If the resident expresses the desire to use a device or a device is in use/recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and /or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Devices will be installed per FDA guidelines b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident's record to include: a. Results of the assessment b. Discussion with resident/responsible party regarding risks and benefits and alternatives considered/recommended c. Decision made/outcome of discussion. 5. Staff will be educated to report to a licensed nurse immediately if the device is found to be loose or malfunctioning. 6. Physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Director of Health	02310		

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	30730	A. BUILDING: _____ B. WING _____	05/22/2025

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02310	Continued From page 45 Services , or Housing Director will be notified immediately. 7. Maintenance staff will inspect bed devices regularly. If the device is loose or unstable, Maintenance will attempt to secure the device. If the device can't be secured, it will be removed and the responsible party will be notified. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) also indicated, "Per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) read, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, Documentation about a resident's hospital-style bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks);	02310		

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02310	Continued From page 46 - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On May 20, 2025, the licensee took action to mitigate risk; however, the scope and level remains unchanged.	02310		

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

Food & Beverage Inspection Report

Establishment Info

Traditions of Montgomery
399 Lexington Ave NW
Montgomery, MN 56069
Parcel:

Phone:

License Info

License: HFID 30730

Risk:
License:
Expires on:
CFPM: Sarah H Schaper (Krause)
CFPM #: 107698; Exp: 8/27/2027

Inspection Info

Report Number: F1033251017
Inspection Type: Full - Single
Date: 5/19/2025 Time: 1:00:08 pM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 5
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: Container of mashed potatoes are covered during cooling.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: Facility is storing utensils in cardboard boxes. Person in charge removed utensils.
Comply By: Complied On Site Originally Issued On: 5/19/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Test kits are expired.
Comply By: 5/30/2025 Originally Issued On: 5/19/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: Kitchen floor is visibly dirty.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.11E *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT: Ice machine has mold buildup inside.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: Hand wash reminder sign is missing from the hand washing sinks in the kitchen.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: Corner wall pieces near dish area are damaged.
Comply By: 5/30/2025 Originally Issued On: 5/19/2025

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 F1033251017 from 5/19/2025

Isaiah Armendariz

Sarah H Schaper (Krause)

Isaiah Armendariz,
Public Health Sanitarian 2
507-344-2743
isaiah.armendariz@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Traditions of Montgomery
Montgomery
County/Group:

Inspection Info

Report Number: F1033251017
Inspection Type: Full
Date: 5/19/2025
Time: 1:00:08 pM

Food Temperature: Product/Item/Unit: Walk In Freezer**; Temperature Process:** Cold-Holding
Location: Walk In Freezer at 0> Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed Potatoes**; Temperature Process:** Cooling
Location: Walk-in Cooler at 75 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Tomatoes**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 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

Traditions of Montgomery
Montgomery
County/Group:

Inspection Info

Report Number: F1033251017
Inspection Type: Full
Date: 5/19/2025
Time: 1:00:08 pM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 50 PPM
Comment:
Violation Issued?: No