Electronically Delivered

March 3, 2025

Licensee
Bridgewater At Mankato
630 Reed Street
Mankato, MN 56001

RE: Project Number(s) SL34568016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34568	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

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0 000	Initial Comments 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: SL234568016 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 23 residents; 22 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (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;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant 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 January 21, 2025 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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: 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.	0 780		

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0 780	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on January 21, 2025, from 11:39 a.m. through 12:31 p.m., with housing manager (HM)-B, the surveyor observed fire rated doors that did not self-close and latch in the following locations: HOUSE TWO 20-minute door into shower room was held open with a toe kick device. When the device was removed the door did not fully close or latch. 20-minute door into laundry room was held open with a toe kick device. When the device was removed the door did not fully close or latch. 20-minute door into employee restroom was held open with a toe kick device. When the device was removed the door did not fully close or latch. One-hour door into kitchen was held open with a magnetic hold that was connected to the fire alarm. When the door was released, it only closed halfway. In the basement storage and mechanical room there was a one-hour fire door that was damaged and did not close and latch. HOUSE ONE 20-minute door into laundry had the door closer	0 780		

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0 780	Continued From page 5 arm removed. The door did not self-close and latch. One-hour door into kitchen was held open with a magnetic hold that was connected to the fire alarm. When the door was released, it did not fully close and latch. 20-minute door into shower room was held open with a toe kick device. When the device was removed the door did not fully close or latch. 20-minute door into employee restroom did not fully close or latch. Fire-resistant rated doors must automatically close and latch to prevent the spread of smoke and fire to adjoining building areas. HM-B stated they understood the requirement and would have the doors adjusted or repaired. During same tour the surveyor observed the smoke alarm outside of the bedroom in resident unit 12, located in the basement of house two, had been removed. The resident re-installed the alarm and HM-B tested the alarms. The smoke alarm inside the bedroom was not interconnected with the smoke alarm located outside in the immediate vicinity of the bedroom. All resident units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the resident unit. HM-B stated they were not aware the resident had removed the alarm. HM-B verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and	0 810		

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0 810	Continued From page 7 evacuation plan with required content and failed to conduct the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 12:40 p.m., housing manager (HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensees FSEP titled "Emergency Operations Program and Plan Manual", revised 8/1/2024, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The plan stated that fire sprinklers would automatically activate but the facility was not equipped with	0 810		

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0 810	Continued From page 8 automatic fire sprinklers. The plan failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. HM-B stated residents were provided training annually. Review of available documents showed that the facilities policy also stated annual training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. HM-B provided documentation indicating that only three fire drills were conducted in 2024. During an interview on January 21, 2025, at 1:15 p.m., HM-B stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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

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01060	Continued From page 10 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 to the Office of Ombudsman for Long-Term Care for one of one resident (R1) who was hospitalized greater than four days. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Elder Service Agreement signed November 11, 2024, indicated R1 received services which included medication administration, blood glucose monitoring, behavior monitoring, weight monitoring, assistance with dressing, CPAP (continuous positive airway pressure) machine, oxygen, laundry, and housekeeping. R1's provider note dated October 24, 2024, indicated R1 was admitted to the hospital October 8, 2024, and discharged to a short-term rehabilitation facility on October 15, 2024. The provider note further indicated R1 returned to the	01060		

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01060	Continued From page 11 licensee on October 21, 2024, (13 days away from the facility). R1's Notification of Emergency Relocation form dated October 8, 2024, indicated notifications had been made to the resident and the resident's case manager. R1's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On January 23, 2025, at 10:44 a.m., house manager (HM)-B stated she was unable to find evidence the Office of Ombudsman for Long-Term Care had been notified when R1 had not returned within four days. HM-B further stated being aware of the requirement. The licensee's Contract Termination policy reviewed September 9, 2024, indicated: 8. Emergency relocation. 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 Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact	01060		

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01060	Continued From page 12 information for the agency to which the resident may submit an appeal. (6) The notice required will be delivered as soon as practicable to: a. the resident, legal representative, and designated representative; b. for residents who receive home and community-based waiver services, the resident's case manager, and; c. the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34568	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 13 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan included the current services provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included type II diabetes mellitus and hypertension. R1's Service Checkoff List dated January 2025, included: Dressing: Physical Assist of one staff to assist with knee-high TEDS (thrombo-embolus deterrent stockings) PRN (as needed), putting on	01650		

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01650	Continued From page 14 in the morning and removing at bedtime. R1's Elder Service Agreement (Plan) signed November 11, 2024, did not include the TED stockings. On January 23, 2025, at 10:44 a.m., clinical nurse supervisor (CNS)-C reviewed R1's service agreement and stated it did not include the assistance with TED stockings. R2 R2's diagnoses included multiple sclerosis. R2's medication administration record (MAR) dated January 2025, included: bacitracin 500 units per gram ointment. Apply topically to infected finger twice a day. R2's Elder Service Agreement (Plan) signed November 7, 2024, did not include the wound care to R2's finger. On January 23, 2025, at 11:59 a.m., clinical nurse supervisor (CNS)-C reviewed R2's service agreement and stated it did not include wound care to the resident's finger. The licensee's Contents of Service Plans policy reviewed July 30, 2024, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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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 medications were maintained bearing the original prescription label for one of five residents (R4) observed during medication administration. 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 provider orders dated January 3, 2025, included: Spiriva 80-4.5 MCG/ACT (micrograms/asthma control test) inhalation aerosol. Inhale two puffs by mouth twice daily. Rinse mouth with water after use. On January 22, 2025, at 7:33 a.m., the surveyor observed unlicensed personnel (ULP)-E set up medications to administer for R4 including the Spiriva inhaler. The inhaler did not include a	01890		

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01890	Continued From page 16 pharmacy label. Clinical nurse supervisor (CNS)-C observed R4's Spiriva inhaler during the medication set-up and stated it should include a prescription label. The licensee's Storage of Medications policy reviewed July 30, 2024, indicated: 2. Proper Storage of Medications b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 17 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01940		

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01940	Continued From page 18 During the entrance conference on January 21, 2025, at 10:29 a.m. clinical nurse supervisor (CNS)-C stated the licensee provided treatment management services to residents, including assistance with oxygen, CPAP (continuous positive airway pressure), and simple wound care. R1 R1's Elder Service Agreement (Plan) signed November 11, 2024, indicated R1 received services which included assistance with CPAP machine and oxygen. R1's provider orders dated January 3, 2025, included: oxygen with CPAP at one liter. On January 22, 2025, at 8:26 a.m., the surveyor observed R1 seated in her recliner chair in her room; a CPAP machine and oxygen concentrator were within reach of the recliner. Oxygen tanks were also observed in the open closet area against the wall. R1 stated she didn't utilize the oxygen tanks at this time, but they were there in case she would need them. R1'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 R1's treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with the resident's oxygen or CPAP machine. R2 R2's After Visit Summary dated November 5,	01940		

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01940	Continued From page 19 2024, indicated a diagnosis of cellulitis to the right index finger. The After Visit Summary included an order for Bacitracin 500 unit/gram ointment; apply one application topically two times a day to infected finger. On January 22, 2025, at 1:45 p.m., the surveyor observed R2's right index finger. The finger was unbandaged, red and raw looking; although did not appear to have any open areas. R2 stated the staff offer to apply Bacitracin to the right index finger daily and then bandage; however, she often declines because she feels she doesn't need it. R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On January 23, 2025, at 11:59 a.m., CNS-C reviewed R2's record and stated it did not include instruction on when to notify a nurse when problems arose with R2's right finger wound. The licensees Individualized Medication, Treatment & Therapy Management Plans policy reviewed July 30, 2024, indicated: 2. Treatment and Therapy Management Plans: RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment and/or therapy services.	01940		

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01940	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01960		

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01960	Continued From page 21 Weekly weights R1's prescriber orders dated July 6, 2022, included an order for weekly weights. R1's Elder Service Agreement signed November 11, 2024, included weekly weight monitoring every Monday; report to nurse any weight change of more than three pounds. R1's Service Checkoff List dated January 2025, did not include evidence R1's weight had been taken on Monday, January 6, 13, or 20, 2025. Further review of R1's record did not include documentation of why the weights had not been taken. CPAP (continuous positive airway pressure) machine cleaning R1's Elder Service Agreement signed November 11, 2024, included daily CPAP cleaning and directed staff to clean mask and tubing of CPAP every morning. Mask to be cleaned with soap and water. Tubing and water chamber does not need to be routinely cleaned unless tap water is being used. Then one part vinegar to three parts water solution is used for cleaning. On January 22, 2025, at 8:15 a.m., unlicensed personnel (ULP)-E stated she doesn't do anything with R1's CPAP machine other than ensure the resident is wearing it when sleeping. ULP-E further stated R1 was independent with managing and cleaning the machine. On November 22, 2025, at 8:26 a.m., the surveyor observed R1 seated in a recliner chair in her apartment. A CPAP machine was sitting on a small table next to the recliner. The CPAP mask and tubing were attached to the machine and	01960		

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01960	Continued From page 22 resting on top of it. R1 stated she should probably clean the CPAP mask and tubing, but she doesn't; staff change out the mask and tubing, "Once in awhile". R1 further stated she adds water to the machine independently. On January 23, 2025, at 10:32 a.m., ULP-D stated she doesn't assist R1 with her CPAP machine because R1 was independent with it. R1's Service Checkoff List dated January 2025, had been signed off as completed for CPAP cleaning 14 out of 23 days; the other nine days were left blank. On January 12, 2025, at 10:44 a.m., house manager (HM)-B and clinical nurse supervisor (CNS)-C reviewed R1's record and stated weight monitoring had not been completed as ordered or documented as refused, and should have been. HM-B and CNS-C further stated staff should be documenting when R1 refuses to have her CPAP machine attachments cleaned and not just signing off that it was completed. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy reviewed July 30, 2024, indicated staff will appropriately document all medications, treatments, and therapy management services provided to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

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01970	Continued From page 23 There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were renewed at least every 12 months for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Elder Service Agreement (Plan) signed November 7, 2024, included weekly weight monitoring and as needed assistance with applying TED (thrombo-embolic deterrent) stockings in the morning and removing at bedtime. R2's record included a provider order dated September 13, 2021, for weekly weight monitoring; if greater than 5 pound weight gain,	01970		

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01970	Continued From page 24 contact R2's neurologist. R2's record further included a provider order dated March 14, 2022, for knee-high TED stockings to be worn as needed; on in the AM and off at HS (hour of sleep/bedtime). R2's record did not include a current order within the past 12 months for weekly weight monitoring or TED stockings. The licensee's Medication & Treatment Orders: Receiving, Renewal, Implementation, and Reordering policy reviewed July 30, 2024, indicated: All medication and treatment orders will be renewed by a prescriber annually or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards related to oxygen storage.	02310		

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02310	Continued From page 25 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 January 22, 2025, at 8:26 a.m., the surveyor observed one unsecured oxygen tank on the floor of the open closet area in R1's room. There were also eight other oxygen tanks secured next to it, in a holder on the floor. On January 23, 2025, at 11:44 a.m., clinical nurse supervisor (CNS)-C and house manager (HM)-B observed the unsecured oxygen tank with the surveyor in R2's room and stated it should be secured. HM-B removed the unsecured oxygen tank from R2's room. The licensee's Safe Oxygen Use and Storage policy reviewed July 30, 2024, indicated: 2. The nurse will educate staff to be alert to any safety concerns related to the use and storage of oxygen, consistent with the manufacturer's instructions. Staff will be trained to reinforce the elder of a safety concern, take steps to eliminate the danger as quickly as possible, and report to the nurse any use or storage of oxygen that is inconsistent with the manufacturer's directions and with the following guidelines: a. Containers must be stored in a well-ventilated area and should not be kept under a bed, in a small area such as a closet or cabinet, or covered by linens or clothing.	02310		

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02310	Continued From page 26 b. Containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage and must not be located in areas where they may be overturned due to a door opening or where they are in a pathway. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/21/25*
Time: 12:00:00
Report: 1033251029

Food and Beverage Establishment Inspection Report

Location:
Bridgewater at Mankato II
640 Reed Street
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0006988
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Bridge Water at Mankato LLC

Phone #: 5073814600
ID #: 51279

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Both kitchens dish machines were measured at 0PPM. Main kitchens dish machine was re-measured at 100PPM.

Comply By: 01/21/25

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

Ice machine drain tube stored in the floor drain in main kitchen.

Comply By: 01/21/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have test kits to measure sanitizing solution.

Comply By: 02/04/25

3-600 Food Identity

3-602.11B

MN Rule 4626.0435B Include the following information on the food label: 1. common name of the food; 2. ingredient list; 3. quantity; 4. manufacturer name and location; 5. allergen declaration; 6. nutrition label, unless exempt; 7. fish color additives.

Powdered creamer and sugar at both locations are missing labels.

Comply By: 01/21/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Both kitchens fire suppression hoods are dirty.

Comply By: 01/21/25

6-200 Physical Facility Design and Construction

6-201.11A

MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.

Ceiling and wall junction has a gap.

Comply By: 01/31/25

Surface and Equipment Sanitizers

Chlorine: = 0PPM at Degrees Fahrenheit
Location: Dish Machine #1
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: Dish Machine #1
Violation Issued: No

Chlorine: = 0PPM at Degrees Fahrenheit
Location: Dish Machine #2
Violation Issued: Yes

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *01/21/25*
Time: 12:00:00
Report: 1033251029
Bridgewater at Mankato II

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer Location #2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Cooler Location #2
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	3

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033251029 of 01/21/25.

Certified Food Protection Manager: Tammy J Walania

Certification Number: FM114771 Expires: 12/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tammy J Walania

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033251029

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/21/25
Time In 12:00:00
Time Out

	Address	City/State	Zip Code	Telephone
Bridgewater at Mankato II	640 Reed Street	Mankato, MN	56001	5073814600

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0006988	Bridge Water at Mankato LLC	Full		L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature	
19	IN OUT N/A N/O	Proper reheating procedures for hot holding	
20	IN OUT N/A N/O	Proper cooling time & temperature	
21	IN OUT N/A N/O	Proper hot holding temperatures	
22	IN OUT N/A	Proper cold holding temperatures	
23	IN OUT N/A N/O	Proper date marking & disposition	
24	IN OUT N/A N/O	Time as a public health control: procedures & records	
Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food	
Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered	
Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used	
28	IN OUT	Toxic substances properly identified, stored, & used	
Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP	

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37	X	Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/21/25

Inspector (Signature)