Electronically Delivered

June 5, 2025

Licensee
The Brooks On St. Paul
2480 St. Paul Road
Owatonna, MN 55060

RE: Project Number(s) SL30837016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 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.

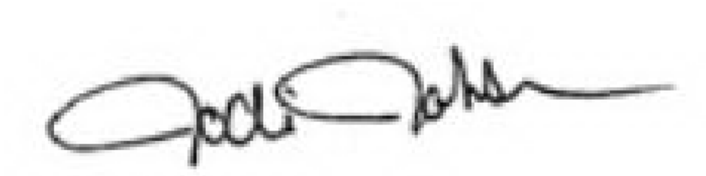
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL30837016-0 On April 21, 2025, through April 24, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 46 residents; 33 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 4 The findings include: On April 21, 2025, at 10:20 a.m. during the facility tour, the surveyor observed a locked box labeled "Grievance Form" which had several copies of the licensee's "Record of Grievance Complaint" document hung above the locked box; however, the surveyor did not observe any signage or information posted regarding the grievance procedure, with the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On April 21, 2025, at 10:57 a.m., licensed assisted living director (LALD)-A stated the grievance procedure with the required content was not posted. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=F	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	0 660		

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0 660	Continued From page 5 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 maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of three employees (unlicensed personnel (ULP)-D and ULP-E). This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on April 2, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record contained a negative QuantiFERON gold blood test dated November 3, 2023. However, the blood test was not completed within 90 days of hire. ULP-E	0 660		

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0 660	Continued From page 6 ULP-E was hired on March 11, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of at two-step TST or other evidence of TB screening such as a blood test. On April 23, 2025, at 9:09 a.m., assistant executive director (AED)-C stated the licensee thought ULP-D's blood test was within the acceptable time frame and could be used. AED-C stated ULP-E had a blood test completed upon hire but could not locate the results in ULP-E's record. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated each staff person would be screened for TB by a two-step skin test or single interferon gamma release assay (IGRA). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 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	01640		

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01640	Continued From page 7 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 signed and revised to reflect the current services provided for two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 7, 2025, with diagnoses that included diabetes. On April 21, 2025, at 11:11 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar. R1 was noted to have a post-surgical boot on her left foot.	01640		

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01640	Continued From page 8 R1's service plan dated April 7, 2025, indicated R1 received assistance with bathing, grooming, toileting, cues for blood sugar checks 3x/day, insulin administration and medication administration. The service plan did not include R1's post-surgical boot. In addition, R1's service plan was not signed by R1 or the licensee. R3 R3 was admitted on March 4, 2021, with diagnoses that included diabetes, chronic kidney disease, and edema. On April 23, 2025, at 9:14 a.m., the surveyor observed R3 wearing bilateral compression wraps. R3 stated the ULP applied the wraps every morning. R3's service plan dated January 1, 2025, indicated R3 received assistance with bathing, nail care, blood pressure monitoring daily, weight monitoring daily, cues for blood sugar checks 4x/day, insulin administration and medication administration, The service plan did not include daily oxygen saturation (O2 sats) monitoring or compression stockings. On April 23, 2025, at 10:41 a.m., clinical nurse supervisor (CNS)-B reviewed R1 and R3's service plans and stated they did not include all the services provided as noted above. CNS-B stated R1's service plan was sent to R1's designated representative, but it had not been returned. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment	01640		

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01640	Continued From page 9 by the registered nurse and/or other licensed health professional. The service plan ad any revisions to service plans would have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse,	01700		

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01700	Continued From page 10 theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of three residents (R1) receiving medication management services. The licensee failed to ensure two of two residents (R2 and R3) who self-administered medications were assessed for self-administration of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 21, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents. R1 R1 was admitted on April 7, 2025, with diagnoses that included diabetes. On April 22, 2025, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-E	01700		

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01700	Continued From page 11 administer medications to R1. R1's service plan dated April 2, 2025, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated April 2025, included the following medications: -Novolog Flexpen; inject 6 units under the skin with meals (diabetes) -acetaminophen 325 milligrams (mg); take two tablets by mouth every morning (pain) -amlodipine 5 mg; take one tablet by mouth once daily (blood pressure) -Blood Sugar Check; check blood sugar three times a day -carvedilol 25 mg; take one tablet by mouth twice a day (blood pressure) -Eliquis 5 mg; take one tablet by mouth twice a day (blood thinner) -isosorbide mononitrate 30 mg; take one tablet by mouth once daily (heart disease) -lisinopril 40 mg; take one tablet by mouth once daily (blood pressure) -Vitamin B12 1000 micrograms (mcg); take one tablet by mouth once daily (supplement) -atorvastatin 80 mg; take one tablet by mouth at bedtime (cholesterol) -Lantus Solostar insulin 100 units/milliliter (ml); inject 19 units subcutaneously at bedtime (diabetes) -acetaminophen 325 mg; take two tablets by mouth every six hours as needed (pain) R1's Medication Management Assessment as found in R1's comprehensive RN assessment dated April 2, 2025, indicated R1 needed assistance with medication administration; however, it lacked evidence the assessment was	01700		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 12 conducted face-to-face with the resident. The assessment did not include an identification and review of all medications the resident was known to be taking, to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Furthermore, the assessment did not identify interventions needed to management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representative on interventions to manage the resident's mediations and prevent diversion of medications. On April 23, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-B and RN-G reviewed R1's medication management assessment and stated R1's assessment did not include the required content as listed above. RN-G stated she had not answered all the questions within the medication assessment which would have included the missing content. ASSESSMENT FOR SELF-ADMINISTRATION R2 R2 was admitted on July 14, 2023, with diagnoses that included dementia and emphysema (lung disease where oxygen and carbon dioxide exchange take place). R2's service plan dated January 1, 2025, indicated R2 received assistance with medication administration. R2's signed prescriber orders dated November 22, 2024, included the following medications: -Breo Ellipta 100 mcg-25 mcg; inhale one puff by	01700		

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	30837	A. BUILDING: _____ B. WING _____	04/24/2025

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01700	Continued From page 13 mouth once daily (emphysema) -fluticasone 50 mcg/ACT nasal spray; inhale two sprays into each nostril once daily (allergies) R2's Medication Management Assessment as found in R2's comprehensive RN assessment dated February 10, 2025, indicated R2 required assistance with medication administration and R2 did not plan to self-administer any medications. The assessment included the following questions which were left blank: -3.b7. Can resident correctly administer inhaled medications safely, if applicable? -3.b8. Can resident correctly administer eye drops, ear drops or eye ointments safely, if applicable? -3.b9. Can resident correctly apply topical ointments, creams, or transdermal patches safely, if applicable? -3.b10. Can resident correctly administer subcutaneous injections safely, if applicable? -3.b.11. Based on the above evaluation, can resident safely self-administer medications without assistance? On April 22, 2025, at 8:21 a.m., the surveyor observed ULP-F prepare R2's medications which included fluticasone nasal spray and Breo Ellipta inhaler. ULP-F brought R2's nasal spray and inhaler to R2 who was seated at the dining room table. R2 blew her nose and then self-administered two sprays in each nostril. ULP-F prepared R2's inhaler and then gave it to her to self-administer. R2 self-administered one puff of the inhaler. R3 R3 was admitted on March 4, 2021, with diagnoses that included diabetes, chronic kidney disease and edema.	01700		

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01700	Continued From page 14 R3's service plan dated January 1, 2025, indicated R3 received assistance with insulin administration 4 x daily and medication administration. R3's signed prescriber orders dated April 11, 2025, included the following medications: -Lyumjev Kwikpen; 100 units/ml; inject 9 units subcutaneously every morning with breakfast (diabetes) -Lyumjev Kwikpen; 100 units/ml; inject 15 units subcutaneously twice daily with lunch and supper (diabetes) -Lantus Solostar insulin 100 units/ml; inject 41 units subcutaneously at bedtime (diabetes) R3's Medication Management assessment as found in R3's comprehensive RN assessment dated April 16, 2025, indicated R3 required assistance with mediation administration and indicated R3 did not plan to self-administer any medications. The assessment included the following questions which were left blank: -3.b7. Can resident correctly administer inhaled medications safely, if applicable? -3.b8. Can resident correctly administer eye drops, ear drops or eye ointments safely, if applicable? -3.b9. Can resident correctly apply topical ointments, creams, or transdermal patches safely, if applicable? -3.b10. Can resident correctly administer subcutaneous injections safely, if applicable? -3.b.11. Based on the above evaluation, can resident safely self-administer medications without assistance? On April 22, 2025, at 11:34 a.m., the surveyor observed ULP-F prepare R3's Lyumjev Kwikpen	01700		

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01700	Continued From page 15 insulin to the prescribed dose of 15 units. ULP-F brought the insulin to R3's room where he self-administered the insulin into his abdomen. On April 23, 2025, at 10:55 a.m., RN-G stated R2 was able to self-administer her nasal spray and inhaler after set by the ULP. RN-G stated R3 was able to self-administer his insulin after the ULP dialed the insulin pen to the prescribed dose. CNS-B and RN-G reviewed R2 and R3's Medication Management Assessments and stated the questions regarding self-administration had not been completed. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated the comprehensive assessment would include: e. Medication review including OTC (over the counter) medications, prescription medications and supplements including: i. Reason taken ii. Side effects, contraindications, allergic or adverse reactions iii. Actions to address side effects, contraindications, allergic or adverse reactions iv. Dosage v. Frequency of use vi. Route administered vii. Resident difficulties taking medications viii. Self-administration vs. other type of administration ix. Resident preferences for taking medications x. Medication management interventions to prevent drug diversion by the resident or others who have access to medications xi. Instructions to the resident and resident's legal/designated representatives on interventions to manage the resident's medications and	01700		

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01700	Continued From page 16 prevent diversion No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730		

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01730	Continued From page 17 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on July 14, 2023, with diagnoses that included dementia and emphysema (lung disease where oxygen and carbon dioxide exchange take place). R2's service plan dated January 1, 2025, indicated R2 received assistance with medication administration.	01730		

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01730	Continued From page 18 R2's medication administration record (MAR) dated April 2025, indicated R2 received medication administration twice daily and as needed. R2's Medication Management Assessment as found in R2's comprehensive RN assessment dated February 10, 2025, indicated R2 required assistance with medication administration. R2's Medication Management Plan dated January 1, 2025, indicated the following: 1) Resident takes oral medications from a med set and her inhalation medications as prescribed by her provider family and her husband manages ordering/setting up her medications so she can self administer. 2) Her husband cues and ensures she takes her medications daily 3) Family/husband orders all medications, and manages overflow medications and ensures they are properly stored 4) Family/husband report adverse effects to medications to the pharmacy and/or MD. If resident is having issues with self administration family/husband have been directed to notify the RN to discuss setting up services for medications administration. The licensee failed to update R2's Individualized Medication Management Plan when R2 moved to memory care and the licensee began managing R2's medication management services. On April 23, 2025, at 11:15 a.m., registered nurse (RN)-G stated R2's Medication Management Plan was not accurate. RN-G stated R2 had previously resided in Assisted Living with her husband who managed all R2's medications. However, R2 had	01730		

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01730	Continued From page 19 moved to Memory Care and the licensee took over managing all R2's medication management services. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated August 1, 2021, indicated the medication, treatment, and therapy management plans will be current and updated when there are changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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 the registered nurse documented resident-specific instructions for one of three residents (R2) whose medication administration was delegated to	01750		

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01750	Continued From page 20 unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted on July 14, 2023, with diagnoses that included dementia and emphysema (lung disease where oxygen and carbon dioxide exchange take place). R2's service plan dated January 1, 2025, indicated R2 received assistance with medication administration. R2's signed prescriber orders dated November 22, 2024, included the following medications: -Breo Ellipta 100 micrograms (mcg)-25 mcg; inhale one puff by mouth once daily (emphysema) -metronidazole 0.75% cream; apply topically to face twice daily (skin irritation) On April 22, 2025, at 8:21 a.m., the surveyor observed ULP-F prepare R2's medications which included Breo Ellipta inhaler and metronidazole cream. ULP-F brought R2's inhaler to R2 who was seated at the dining room table. ULP-F prepared R2's inhaler and then gave it to her to self-administer. R2 inhaled one puff of the inhaler. ULP-F did not offer or instruct R2 to rinse her mouth after administering the inhaler. ULP-F applied a pea size amount of metronidazole	01750		

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01750	Continued From page 21 cream onto her gloved hand and applied the cream to R2's nose and cheeks. The surveyor inquired how ULP knew how much of the topical cream to apply, and ULP-F stated she used what she thought was enough to cover the bridge of R2's nose and both cheeks. On April 23, 2025, at 10:56 a.m., registered nurse (RN)-G stated ULP-F should have residents rinse their mouths after using an inhaler. RN-G stated R2's order for metronidazole did not include the amount to administer and contacted R2's provider to obtain clarification on the amount to administer. The licensee's Content of Medication Prescriptions ad Treatment or Therapy Orders policy dated August 1, 2021, indicated: A medication prescription must include: a. the date of issue b. name and address of the resident c. name and quantity of the drug prescribed d. dosage, route and any specific directions for use e. name and address of the prescriber and telephone number where the prescriber can be reached f. the prescriber's manual or electronic signature g. if the prescription is for a PRN (as needed) medication or medication with a variable dosage does not include clear parameters for administration, the RN or LPN will notify the prescriber and obtain the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 22	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of three residents (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on April 7, 2025, with diagnoses that included diabetes.	01760		

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01760	Continued From page 23 On April 22, 2025, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service plan dated April 2, 2025, indicated R1 received assistance with medication administration. R1's signed prescriber orders dated March 25, 2025, included: -acetaminophen 500 milligrams (mg); take 1-2 tablets by mouth as needed for pain -ibuprofen 200 mg; take 600 mg by mouth as needed for pain R1's medication administration record (MAR) dated April 2025, did not include the ibuprofen order or acetaminophen 500 mg order. On April 23, 2025, clinical nurse supervisor (CNS)-B reviewed R1's signed prescriber orders and MAR and stated R1's ibuprofen and acetaminophen order had not ben transcribed into R1's record. The license's Content of Medication Prescriptions and Treatment or Therapy Orders policy dated August 1, 2021, indicated the nurse was responsible for ensuring that current, authorized prescriber prescriptions for medications and orders for treatments and therapies to be administered by the staff were kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01940	Continued From page 24	01940		
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 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	01940		

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01940	Continued From page 25 plan to include all required content for two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 7, 2025, with diagnoses that included diabetes. On April 21, 2025, at 11:11 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar. R1 was noted to have a post-surgical boot on her left foot. R1's service plan dated April 7, 2025, indicated R1 received cues for blood sugar checks 3x/day. The service plan did not include R1's post-surgical boot. R1's Service Checkoff list document dated April 2025, indicated R1 received assistance with the following: -Dressing: Physical Assist 1. Please help to put on her post-op shoe to her L (left) foot for the day. -FSBG (fasting blood glucose) 4x daily; unlicensed assistive personnel to perform FSBG test per physician order. R1's signed prescriber orders dated April 14, 2025, included the following:	01940		

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THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

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01940	Continued From page 26 -Test blood glucose 4x daily -wear post op shoe to left foot for next month during ambulation R1's Treatment/Therapy Management Program as found in R1's comprehensive RN assessment dated April 21, 2025, indicated "resident does not receive any treatments/therapy". R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. R3 R3 was admitted on March 4, 2021, with diagnoses that included diabetes, chronic kidney disease and edema. On April 23, 2025, at 9:14 a.m., the surveyor observed R3 wearing bilateral compression wraps. R3 stated the ULP applied the wraps every morning. R3's service plan dated January 1, 2025, indicated R3 received assistance with blood	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 pressure monitoring daily, weight monitoring daily and cues for blood sugar checks 4x/day, The service plan did not include daily Oxygen saturation (O2 sats) monitoring or compression stockings. R3's signed prescriber orders dated January 22, 2025, included the following: -measure O2 saturations (O2 sats) daily at rest and with activity -Weight daily in the morning R3's record lacked prescriber orders for the following treatments: -Compression stockings/wraps -Blood sugar checks 4x/day -Blood pressure checks R3's Service Checkoff List dated April 2025, included the following: -Blood Pressure Monitor Daily; resident takes his blood pressure every morning- staff to document results ad report concerns to nursing. Take and document resident blood pressure. -Cue FSBG 4x daily; resident takes blood sugar on his own-record results. -Oxygen Saturation Monitoring Daily; Staff monitor O2 sats twice a day. At resident and with activity. Report to nurse if O2 sat is less than 90% at rest. -TED: Physical Assist 1: He will let you know if he needs help and is wearing. Will not wear at times de to wound on leg. Resident Assistant to provide physical assistance to resident to apply and remove compression hose/brace/etc. -Weight Monitor Daily, check weight in morning before breakfast. Resident weighs himself and tell you what his numbers were. You need to record the weight. Obtain and document resident weight.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 28 R3's Treatment/Therapy Management Program as found in R3's comprehensive RN assessment dated April 16, 2025, indicated "Resident requires assistance with treatment/therapy management". R3's Treatment/Therapy Management Plan dated January 1, 2025, lacked the following required content: - statement of all the type of service that will be provided (blood pressure checks, O2 saturation checks, daily weights); - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel On April 23, 2025, at 9:20 a.m., registered nurse (RN)-G stated R1 and R3's individualized treatment management plan lacked the required content as noted above. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated August 1, 2021, indicated the treatment and therapy management plan will include: a. statement of the type of service(s) provided b. documentation of specific resident instructions relating to the treatments and/or therapy administration c. identification of treatment or therapy tasks that may be delegated to an unlicensed staff member d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services e. Resident-specific requirements relating to documentation of treatment and therapy received,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 29 verification that all treatment and therapy was administered as prescribed, and monitoring of treatment and/or therapy to prevent possible complications or adverse reactions Medication, treatment, and therapy management plans will be current and updated when there are changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of three residents (R2 ad R3) 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	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 30 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 was admitted on July 14, 2023, with diagnoses that included dementia and emphysema (lung disease where oxygen and carbon dioxide exchange take place). R2's service plan dated January 1, 2025, indicated R2 received assistance with TED (thrombo-embolic deterrent) stockings (stockings that prevent blood clots and swelling in the legs). R2's Service Checkoff List dated April 2025, indicated R2 received assistance with TED stockings every day. R2's record lacked prescriber orders for TED stockings. R3 R3 was admitted on March 4, 2021, with diagnoses that included diabetes, chronic kidney disease and edema. R3's service plan dated January 1, 2025, indicated R3 received assistance with blood pressure monitoring daily, weight monitoring daily and cues for blood sugar checks 4x/day, The service plan did not include daily oxygen saturation (O2 sats) monitoring or compression stockings. R3's Service Checkoff List dated April 2025, included the following:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 31 -Blood Pressure Monitor Daily; resident takes his blood pressure every morning- staff to document results ad report concerns to nursing. Take and document resident blood pressure. -Cue fasting blood glucose (FSBG) 4x daily; resident takes blood sugar on his own-record results. -Oxygen Saturation Monitoring Daily; Staff monitor O2 sats twice a day. At rest and with activity. Report to nurse if O2 sat is less than 90% at rest. -TED: Physical Assist 1: He will let you know if he needs help and is wearing. Will not wear at times due to wound on leg. Resident Assistant to provide physical assistance to resident to apply and remove compression hose/brace/etc. -Weight Monitor Daily, check weight in morning before breakfast. Resident weighs himself and tell you what his numbers were. You need to record the weight. Obtain and document resident weight. R3's signed prescriber orders dated January 22, 2025, included the following: -measure O2 saturations daily at rest and with activity -Weight daily in the morning R3's record lacked prescriber orders for the following treatments: -Compression stockings/wraps -Blood sugar checks 4x/day -Blood pressure checks On April 23, 2025, at 9:16 a.m., registered nurse (RN)-G stated R2 and R3's record lacked signed prescriber orders for the treatments noted above. The licensee's Content of Mediation Prescriptions and Treatment or Therapy Orders policy dated	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 32 August 1, 2021, indicated an order for a treatment or therapy must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02140	Continued From page 33 or has the potential to affect a large portion or all the residents). The findings include: The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license effective September 1, 2024. During the entrance conference on April 21, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated the clinical nurse supervisor (CNS)-B oversaw the staff training in the care of individuals with dementia. On April 23, 2025, at 10:45 a.m., CNS-B stated registered nurse (RN)-G oversaw the staff training in the care of individuals with dementia for the licensee. On April 24, 2025, at 8:49 a.m., CNS-B provided a Certificate of Completion for RN-G. The certificate indicated RN-G successfully completed the course "AL Dementia Knowledge Test" on February 24, 2025. CNS-B stated the training was through Relias. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed, and Relias trainings were not included in the list of approved training programs for the designated person to oversee staff training by the commissioner. On April 24, 2025, at 1:00 p.m., they surveyor and CNS-B reviewed the approved list of dementia care training programs and CNS-B stated RN-G had not completed courses from the approved	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30837	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKS ON ST PAUL	2480 ST. PAUL ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02140	Continued From page 34 list. CNS-B stated she was unaware the Relias training did not meet the requirement according to the approved list provided by the commissioner and would notify the corporate office. The licensee's Training Requirement for Assisted Living with Dementia Care policy dated July 2021, indicated persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia including: - Two years of work experience related to Alzheimer's disease or other dementia's or in health care, gerontology, or another related field - Completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/22/25*
Time: 09:10:09
Report: 8044251108

Food and Beverage Establishment Inspection Report

Location:
The Brooks On St Paul - Memory Care
2480 St. Paul Road
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037828
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074665854
ID #:

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

No NEW orders were issued during this inspection.

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Establishment Info: micahstaloch@ecumen.org

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044251108 of 04/22/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Signed:_____
Inspector signed for Micah

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/22/25*
Time: 08:14:38
Report: 8044251107

Food and Beverage Establishment Inspection Report

Location:
The Brooks On St Paul
2480 St. Paul Road
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037828
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074665854
ID #:

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.

5-200B Plumbing: cross connections

5-203.14I ***** Priority 1 *****

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

Pressure relief device installed on mop sink faucet not working correctly to relieve pressure when water is turned on without using chemical dispensers.

Comply By: 05/06/25

5-400 Sewage

5-402.11A ***** Priority 1 *****

MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.

No air gap with floor drain for ice machine drain hose.

Comply By: 05/06/25

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Food residues on can opener.

Comply By: 04/22/25

5-200C Plumbing: Maintenance, fixture location

5-205.13 ***** Priority 2 *****

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

Water filter for ice machine dated 10/23, past due for the recommended annual replacement.

Leaking vacuum breaker for mop sink faucet.

Comply By: 05/06/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Lactic Acid: = 1875ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Hot Water: = at 164.5 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold holding
Temperature: 37.3 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold holding
Temperature: 36.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cold holding
Temperature: 40.1 Degrees Fahrenheit - Location: Sliced cheeses in prep
Violation Issued: No

Process/Item: Cold holding
Temperature: 40.0 Degrees Fahrenheit - Location: Prep
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	2	0

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Director Micah Staloch.

Establishment Info: micahstaloch@ecumen.org

Type: Full
Date: *04/22/25*
Time: 08:14:38
Report: 8044251107
The Brooks On St Paul

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044251107 of 04/22/25.

Certified Food Protection Manager: Dominique E. Highberg

Certification Number: 113427 Expires: 10/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Micah

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us

Report #: 8044251107

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

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

Date 04/22/25
Time In 08:14:38
Time Out

The Brooks On St Paul	Address: 2480 St. Paul Road	City/State: Owatonna, MN	Zip Code: 55060	Telephone: 5074665854
License/Permit #: 0037828	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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
Surpervision							
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		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		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52	X	Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		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:** 04/22/25

Inspector (Signature) _____