



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2025

Licensee

Abilit Holdings (Prairie Meadow)

800 5th Avenue Northwest

Kasson, MN 55944

RE: Project Number(s) SL24053016

Dear Licensee:

On July 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 7, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 7, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 7, 2025, found not corrected at the time of the July 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

- 1460 - Orientation Of Staff And Supervisors - 144g.63 Subdivision 1 - \$500.00**
- 1470 - Content Of Required Orientation - 144g.63 Subd. 2 - \$500.00**
- 1540 - Training In Dementia, Mental Illness, And De -- 144g.64 (a) (3) - \$500.00**
- 1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E) - \$500.00**
- 1940 - Individualized Treatment Or Therapy Managemen - 144g.72 Subd. 3 - \$500.00**
- 1970 - Treatment And Therapy Orders - 144g.72 Subd. 6 - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on July 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 21, 2025, we identified the following violation(s):

- 1370 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (a)**
- 1380 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (b)**

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/21/2025
NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADOW)			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SLSL24053016-1 On July 21, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 7, 2025. At the time of the survey, there were 61 residents; 56 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{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}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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:	{0 480}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this survey.		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}	Not reviewed during this survey.		

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{0 800}	Continued From page 3	{0 800}			
	This MN Requirement is not met as evidenced by:				
{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	{0 810}	Not reviewed during this survey.		

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01370	Continued From page 5 (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of four employees (unlicensed personnel (ULP)-I) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I was hired on February 19, 2025, to provide direct care and services to the facility's residents. ULP-I's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided;	01370			

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01370	Continued From page 6 -reports of changes in the resident's condition not the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, ad treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices In addition, ULP-I's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices	01370			

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01370	Continued From page 7 -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them On July 21, 2025, at 2:12 p.m., licensed assisted living director (LALD)-A stated ULP-I's record lacked evidence of training and competency evaluations as listed above. Regional nurse specialist (RNS)-K stated ULP-I would be removed from working on the floor until the above training and competencies were completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training ad competency evaluations for all ULP will include: - documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the home care provider -maintenance of clean and safe environment -appropriate and safe techniques in person hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -training on the prevention of falls for providers working with the elderly or individuals at risk of falls -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -communication skills that include preserving the	01370			

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01370	Continued From page 8 dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -understanding appropriate boundaries between staff and residents and the resident's family -awareness of commonly used health technology equipment and assistive devices No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01380			

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01380	Continued From page 9 was completed for one of four employees (unlicensed personnel (ULP)-I) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I was hired on February 19, 2025, to provide direct care and services to the facility's residents. ULP-I's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; -basic knowledge of body functioning and changes I body functioning, injuries or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required In addition, ULP-I's employee record lacked evidence of competency evaluation for the following topics: -reading and recording temperature, pulse, and	01380			

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01380	Continued From page 10 respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. On July 21, 2025, at 2:12 p.m., licensed assisted living director (LALD)-A stated ULP-I's record lacked evidence of training and competency evaluations as listed above. Regional nurse specialist (RNS)-K stated ULP-I would be removed from working on the floor until the above training and competencies were completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training ad competency evaluations for all ULP will include: -observation, reporting, and documenting of resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel -reading and recording temperature, pulse, and respirations of the resident -recognizing physical, emotional, cognitive, and developmental needs of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments are required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors	{01460}			

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{01460}	Continued From page 11 (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four employees	{01460}			

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{01460}	Continued From page 12 (unlicensed personnel (ULP)-D and ULP-I) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired on August 13, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license.	{01460}			

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{01460}	Continued From page 13 On July 21, 2025, at 12:02 p.m., licensed assisted living director (LALD)-A stated ULP-D had not been assigned or completed the required orientation to assisted living facility licensing requirements training since the initial survey completed on May 7, 2025. LALD-A stated he thought ULP-D's training documents from when she was an agency employee for the licensee met the orientation requirements. LALD-A stated ULP-D was hired as a permanent employee on August 13, 2024. ULP-I ULP-I was hired on February 19, 2025, to provide direct care and services to the facility's residents. ULP-I's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On July 21, 2025, at 2:12 p.m., LALD-A stated he was unable to print ULP-I's training transcript; however, upon further review, ULP-I had not completed any of the required orientation training that had been assigned to her. Regional nurse	{01460}			

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{01460}	Continued From page 14 specialist (RNS)-K stated ULP-D and ULP-I would be removed from working on the floor until this training was completed. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -Handling of emergencies and use of emergency services -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning ad service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services	{01460}			

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{01460}	Continued From page 15 -A review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided.	{01460}			
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	{01470}			

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{01470}	Continued From page 16 services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four employees (unlicensed personnel (ULP)-C) received orientation to assisted living facility licensing requirements and regulations before providing 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	{01470}			

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{01470}	Continued From page 17 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on January 13, 2025, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the following required orientation content: - Overview of Assisted Living statutes; - Assisted Living Bill of Rights; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services On July 21, 2025, at 12:10 p.m., licensed assisted living director (LALD)-A stated he was having difficulties printing training transcripts for some employees, including ULP-C. LALD-A stated he reviewed ULP-C's training record and stated ULP-C had not completed any orientation training as listed above since the initial survey completed on May 7, 2025. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights	{01470}			

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{01470}	Continued From page 18 -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services No further information was provided.	{01470}			
{01540} SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	{01540}			

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{01540}	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four employees (unlicensed personnel (ULP)-C, ULP-D, ULP-I and ULP-L) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: The licensee had an Assisted Living with Dementia Care license. ULP-C ULP-C was hired on January 13, 2025, to provide direct care and services to the licensee's residents. ULP-C's employee record contained evidence the employee received three hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-D ULP-D was hired on August 13, 2024, to provide direct care and services to the licensee's	{01540}			

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{01540}	Continued From page 20 residents. ULP-D's employee record did not include evidence of any initial dementia care training within 80 working hours of the employment start date. ULP-D's record lacked evidence that ULP-D completed any additional dementia car training since the initial survey completed on May 7, 2025. ULP-I ULP-I was hired on February 19, 2025, to provide direct care and services to the licensee's residents. ULP-I's employee record contained evidence the employee received one hour of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-L ULP-L was hired on September 23, 2024, to provide direct care and services to the licensee's residents. ULP-L's employee record did not include evidence of any initial dementia care training within 80 working hours of the employment start date. On July 21, 2025, at 1:30 p.m., licensed assisted living director (LALD)-A and regional nurse specialist (RNS)-K stated they thought the ULP-C, ULP-D, ULP-I and ULP-L had completed all dementia training. However, upon further investigation of their training transcripts, they noted the ULP's transcripts only listed the required training as being assigned not	{01540}			

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{01540}	Continued From page 21 completed. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight hours of initial training within 80 hours of the employment start date. No further information was provided.	{01540}			
{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 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 interview and record review, the licensee failed to ensure the current service plan	{01640}			

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{01640}	Continued From page 22 was signed by the resident/resident representative and the licensee for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan July 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, compression stockings, dressing, bathing, transferring, and medication administration. The service plan was not signed by R3 or R3's representative or by the licensee. On July 21, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated R3's service plan was not signed by R3, R3's representative, or the licensee. CNS-B stated she had updated R3's service plan since the initial survey was completed on May 7, 2025; however, R3's daughter had not signed the service plan yet. CNS-B stated R3's daughter would be in this week to review and sign R3's service plan. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or another	{01640}			

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{01640}	Continued From page 23 authentication by [licensee name] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01640}			
{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	{01940}			

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{01940}	Continued From page 24 changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan 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 March 15, 2023, with diagnoses that included Alzheimer's disease. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include compression stockings. R2's signed prescriber orders included the following: -Gradient compression garments and supplies; [R2's name] requires this compression garment due to lower extremity. This is needed for the bilateral side of the body, order dated April 2, 2024. R2's Medication and Treatment Assessment Plan dated July 1, 2025, did not include compression stockings.	{01940}			

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{01940}	Continued From page 25 R2's Medication and Treatment Assessment Plan dated July 1, 2025, lacked the following: -statement of the type of service that will be provided, compression stockings -documentation of specific resident instructions relating to the treatments or therapy administration, for compression stockings. On July 21, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated R2's treatment plan lacked the required content as noted above. CNS-B stated she thought she updated R2's treatment plan after the initial survey completed on May 7, 2025, but must have missed this. 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. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the registered nurse or licensed health professional will document instructions for the delegated tasks in the resident's record. No further information was provided.	{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	{01970}			

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{01970}	Continued From page 26 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 maintained for one of three residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on March 15, 2023, with diagnoses that included Alzheimer's disease. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include compression stockings. R2's signed prescriber orders included the following: -Gradient compression garments and supplies; [R2's name] requires this compression garment due to lower extremity. This is needed for the bilateral side of the body, order dated April 2, 2024. R2's record did not include a current order within	{01970}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
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{01970}	Continued From page 27 the past 12 months for compression stockings. On July 21, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated R2's record lacked a current prescriber order for compression stockings. CNS-B stated she thought she added compression stockings to R2's list of medications and treatments that she sent to R2's primary care provider (PCP); however, upon review of R2's recent prescriber orders, compression stockings were not included. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the nurse was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The licensed nurse will communicate with the prescriber to assure that the prescriber renews a mediation or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided.	{01970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 17, 2025

Licensee

Abilit Holdings (Prairie Meadows LLC)

800 5th Ave Northwest

Kasson, MN 55944

RE: Project Number(s) SL24053016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2025
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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: SL24053016-0 On May 5, 2025, through May 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 63 residents; 57 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate order was issued on May 5, 2025, at a level 3/Widespread (I). The licensee took action on May 5, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license, effective February 1, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on November 29, 2024. As a result of this survey, the following orders were issued under 0480, 0550, 0680, 0690, 0730, 0775, 0800, 0810, 0950, 1460, 1470, 1540, 1620, 1640, 1730, 1750, 1770, 1790, 1820, 1830, 1940, 2140, and 2310, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480			

Minnesota Department of Health

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

Minnesota Department of Health

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0 480	Continued From page 4 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 May 5, 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			

Minnesota Department of Health

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0 550	Continued From page 5	0 550			
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			

Minnesota Department of Health

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0 550	Continued From page 6 The findings include: On May 5, 2025, at 10:30 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the licensee's grievance procedure posted on the wall outside of the LALD's office and an additional grievance posting in the memory care entryway. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the two postings had contact information for a previous employee. The postings lacked the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On May 6, 2025, at 9:17 a.m., LALD-A reviewed the posted grievance procedure and stated it did not include the name, telephone number, and email contact for the individuals who were responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680			

Minnesota Department of Health

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0 680	Continued From page 7 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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:	0 680			

Minnesota Department of Health

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0 680	Continued From page 8 The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following: -conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On May 7, 2025, at 10:53 a.m., licensed assisted living director (LALD)-A stated the EP plan lacked the required training as noted above. LALD-A stated the licensee was planning to conduct the required training in the near future. The licensee's Emergency Preparedness Manual policy, undated, indicated Assisted Living residents would participate in a full-scale exercise that is community-based if possible (once a year). If participation in a community-based exercise is not possible, then the health center must conduct a tabletop exercise. An additional exercise will need to be conducted such as a full -scale exercise that is community-based or community specific or a tablet-top exercise that includes a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Testing needs to be done to include an analysis of the health center's response, and to maintain documentation of all drills, tabletop exercises,	0 680			

Minnesota Department of Health

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0 680	Continued From page 9 and emergency events. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: R1 R1 was admitted on December 15, 2023, with diagnoses that included anxiety and depression.	0 690			

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NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
(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
0 690	Continued From page 10 R1's service plan dated March 28, 2025, indicated R1 received assistance with services to include grooming, dressing, repositioning, toileting, bathing, mobility/ambulation, transfers and medication administration. R1's Medication Administration Record (MAR) dated May 2025, included staff initials and names, but lacked their credentials/title. R1's Comprehensive Assessment dated March 27, 2025, included the staff name for the person who completed the assessment, but lacked the credentials/title. R2 R2 was admitted on March 15, 2023, with diagnoses that included Alzheimer's disease. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include dressing, compression stockings, bathing and medication administration. R2's MAR dated May 2025, included staff initials and names, but lacked their credentials/title. R2's Comprehensive Assessment dated April 4, 2025, included a staff name for the person who completed the assessment, but lacked their credentials/title. R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, compression stockings, dressing, bathing, transferring, and	0 690			

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0 690	Continued From page 11 medication administration. R3's MAR dated May 2025, included staff initials and names, but lacked their credentials/title. R3's Comprehensive Assessment dated April 16, 2025, included a staff name for the person who completed the assessment, but lacked their credentials/title. On May 7, 2025, at 9:21 a.m., clinical nurse supervisor (CNS)-B stated the staff credentials/title were not included on any of the residents' MARs or comprehensive assessments. CNS-B stated she would contact the corporate office to have this fixed. The licensee's Resident Record-Information and Content policy dated August 1, 2021, indicated all entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;	0 730			

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0 730	Continued From page 12 (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730			

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0 730	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required content in a discharge summary for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on March 10, 2025, and discharged to home with their spouse on April 30, 2025. R4's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the	0 730			

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0 730	Continued From page 14 resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On May 7, 2025, at 9:18 a.m., clinical nurse supervisor (CNS)-B stated she had not completed a discharge summary for R4 until "today," (May 7, 2025). The licensee's Resident Record- Information and Content policy dated August 1, 2021, indicated a resident's record would include a discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 775			

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0 775	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On May 6, 2025, from 10:45 a.m. to 2:30 p.m., the surveyor toured the facility with maintenance assistant (MA)-G and maintenance director (MD)-F. During the tour, the surveyor observed: SMOKE ALARMS: In resident room 315, and battery alarm was found where a hard-wired alarm should be connected. Hard-wired alarms are to be maintained in a facility and not replaced with battery powered alarms. In resident rooms the combo smoke/carbon monoxide alarm was in the sleeping room while smoke alarm was in the hallway outside the sleeping room. Carbon monoxide alarm shall within 10' of all sleeping rooms. SPRINKLER REPORT Annual sprinkler report provided by MD-F; the sprinkler report had deficiencies that were not corrected at time of survey. FIRE DOORS: Fire doors in the South side of the basement had missing or broken door closer's. Swinging fire doors shall close from the full-open position and latch automatically. EXIT OBSTRUCTION: In the dementia area of the facility, the rear	0 775			

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0 775	Continued From page 16 marked exit leads to a enclosed patio area for the residents. The gate to exit this area into the public way was held closed with zip ties around the maglock. The exit to the public way, shall provide a direct and unobstructed access. TRASH ROOMS: In both basement trash collection rooms, chute doors were held open with rope. Chute doors shall be self- or automatic closing upon the detection of smoke. During a facility tour on May 6, 2025, at 12:30 p.m., MA-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800			

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0 800	Continued From page 17 residents. This deficient condition had the potential to affect all staff, residents, 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 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). On a facility tour on May 5, 2025, from 10:30 a.m. to 1:30 p.m., with maintenance assistant (MA)-G. The following was observed. FLOOR: Floor was soft and sponge like near office 2-12 to the elevators, resident room 208/209 and outside of the director's office. On May 6, 2025, at 12:30 p.m., licensed assisted living director (LALD)-A stated they are waiting on a housing grant to repair the floors in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
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	0 810			

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0 810	Continued From page 18 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, provide 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	0 810			

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0 810	Continued From page 19 or has potential to affect a large portion or all of the residents). The findings include: During facility tour on May 6, 2025, from 10:45 a.m. to 2:30 p.m., May 6, 2025, from 10:45 a.m. to 2:30 p.m., with licensed assisted living director (LALD)-A; 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 licensee's FSEP, titled "Fire Policy", undated, failed to include the following: RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On May 6, 2025, at 12:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party	0 810			

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0 810	Continued From page 20 provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No other training documentation was provided. On April 6, 2025, at 12:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire/Disaster Drill Log", undated, indicated evacuation fire drills were conducted quarterly for each shift exceeding the requirement of 2 drills per shift each year but not doing drills every other month. No other documentation was provided. On May 5, 2025, at 12:30 p.m., LALD-A stated he understood the stature requirements and will ask reconsideration if an exception or adjustment can be made. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

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0 810	Continued From page 21 (21) days.	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided	0 950			

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0 950	Continued From page 22 the required notice for right to a designated representative with the required verbiage on a document separate from the contract for three of three residents (R1, R2 and R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: R1 R1 was admitted on December 15, 2023, with diagnoses that included anxiety and depression. R1's service plan dated March 28, 2025, indicated R1 received assistance with services to include grooming, dressing, repositioning, toileting, bathing, mobility/ambulation, transfers and medication administration. R1's Resident Occupancy Agreement dated December 15, 2023, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative	0 950			

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0 950	Continued From page 23 can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted on March 15, 2023, with diagnoses that included Alzheimer's disease. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include dressing, compression stockings, bathing and medication administration. R2's Resident Occupancy Agreement dated June 12, 2024, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950			

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0 950	Continued From page 24 R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, compression stockings, dressing, bathing, transferring, and medication administration. R3's Resident Occupancy Agreement dated April 27, 2023, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R3's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On May 7, 2025, at 8:14 a.m., licensed assisted living director (LALD)-A reviewed a blank copy of the licensee's Resident Occupancy Agreement and stated it did not include a document separate from the contract verbatim notice of Right to Designate a Representative for Certain Purposes.	0 950			

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0 950	Continued From page 25 LALD stated the same Resident Occupancy Agreement was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's	01460			

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01460	Continued From page 26 category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on August 13, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors;	01460			

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01460	Continued From page 27 - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On May 6, 2025, at 11:01 a.m., assistant community director (ACD)-H stated ULP-D had not been assigned or completed the orientation to assisted living facility licensing requirements training. On May 7, 2025, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated ULP-D's record lacked evidence of completing orientation to assisted living facility as required. CNS-B stated ULP-D had been an agency employee and later hired as a permanent employee. CNS-B stated it was an oversight that ULP-D was not assigned the required orientation when hired on as a permanent employee for the licensee. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -Handling of emergencies and use of emergency	01460			

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01460	Continued From page 28 services -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning ad service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470			

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01470	Continued From page 29 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470			

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01470	Continued From page 30 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received orientation to assisted living facility licensing requirements and regulations before providing 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: ULP-C was hired on January 13, 2025, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the following required orientation content: - Overview of Assisted Living statutes;	01470			

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01470	Continued From page 31 - Assisted Living Bill of Rights; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services On May 6, 2025, at 11:01 a.m., assistant community director (ACD)-H stated ULP-C had not completed the required orientation as listed above. On May 7, 2025, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated ULP-C's record lacked evidence of completing orientation to assisted living as listed above. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services No further information was provided.	01470			

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01470	Continued From page 32	01470			
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01540			

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01540	Continued From page 33 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license. ULP-C ULP-C was hired on January 13, 2025, to provide direct care and services to the licensee's residents. On May 5, 2025, at 11:58 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C's employee record contained evidence the employee received one hour of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-D ULP-D was hired on August 13, 2024, to provide direct care and services to the licensee's residents. On May 6, 2025, at 6:55 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record did not include evidence of any initial dementia care training within 80 working hours of the employment start date. On May 6, 2025, at 11:01 a.m., assistant community director (ACD)-H stated ULP-D had not been assigned or completed any dementia	01540			

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01540	Continued From page 34 care training. ACD-H stated ULP-C had completed one hour of dementia care training and provided a printed certificate of this training. On May 7, 2025, at 9:51 a.m., ACD-H stated she assigned the required dementia training to all employees based on their hired position. ACD-H stated each employee was assigned one dementia course at the time of hire which did not meet the required eight hours of dementia training. ACD-H stated she was not aware of the eight-hour dementia care training requirement. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620			

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01620	Continued From page 35 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, compression stockings, dressing, bathing, transferring, and medication administration.	01620			

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01620	Continued From page 36 R3's ongoing nursing assessments dated October 2, 2024, January 4, 2025, January 16, 2025, and April 16, 2025, were reviewed. The January 4, 2025, assessment was completed 94 days after the date of the previous assessment, thus exceeding 90 calendar days. On May 7, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated R3's January 4, 2025, assessment was not completed within the required time frame. CNS-B stated the licensee had recently switched electronic health record systems and the late assessment was an oversight during the transition. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640			

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01640	Continued From page 37 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan was signed by the resident/resident representative and the licensee 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 December 15, 2023, with diagnoses that included anxiety and depression.	01640			

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01640	Continued From page 38 R1's service plan dated March 28, 2025, indicated R1 received assistance with services to include grooming, dressing, repositioning, toileting, bathing, mobility/ambulation, transfers and medication administration. The service plan was not signed by R1 or R1's representative or by the licensee. R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, compression stockings, dressing, bathing, transferring, and medication administration. The service plan was not signed by R3 or R3's representative or by the licensee. On May 7, 2025, at 9:26 a.m., clinical nurse supervisor (CNS)-B stated R1 and R3's service plans were not signed. CNS-B stated she was waiting for R1 and R3's representatives to sign and return the service plans. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or another authentication by [licensee name} and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01730	Continued From page 39	01730			
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, 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.	01730			

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01730	Continued From page 40 (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 (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on December 15, 2023, with diagnoses that included anxiety and depression. R1's service plan dated March 28, 2025, indicated R1 received assistance with medication administration. The service plan was not signed by R1 or R1's representative or by the licensee. R1's medication administration record (MAR) dated May 2025, indicated R1 received medication administration four times a day and as needed. R1's Medication/Treatment Assessment dated March 27, 2025, indicated "all medications are	01730			

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01730	Continued From page 41 self-administered". The licensee failed to update R1's Individualized Medication Management Plan when R1 had a change in condition and was no longer able to self-administer her medications. On May 7, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated R1 used to self-administer all her mediations; however, after a recent hospitalization and change in condition, the licensee now managed and administered all of R1's medications. CNS-B further stated R1's medication plan did not accurately reflect the current medication services R1 received. 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=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750			

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01750	Continued From page 42 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-D) was determined competent by a registered nurse (RN) to administer medications. This had the potential to affect all residents receiving medication administration. The licensee further failed to ensure the RN documented resident-specific instructions for one of three residents (R3) whose medication administration was delegated to ULP. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-D was hired on August 13, 2024, to provide direct care and services to the licensee's residents. On May 6, 2025, at 6:55 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee file lacked evidence of competencies for medication administration had been completed by a RN.	01750			

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01750	Continued From page 43 ULP-D's record contained a Supervision of Personnel form dated March 18, 2025, which indicated ULP-D performed medication administration adequately and appropriately when observed by the facility RN. On May 6, 2025, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated ULP-D had not been competency tested on medication administration because she had a trained medication aide (TMA) certificate. CNS-B further stated she was told if a ULP had a TMA certificate they were not required to competency test them on medication administration. CNS-B stated she observed and supervised all ULP on medication administration periodically and had no concerns with ULP-D's ability to administer medications during those observations. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of [licensee name] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. RESIDENT-SPECIFIC INSTRUCTIONS R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include medication administration.	01750			

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01750	Continued From page 44 R3's signed prescriber orders dated April 9, 2025, included: -albuterol 90 micrograms (mcg)/actuation inhaler: inhale two puffs three times a day -diclofenac sodium 1% gel; apply 4 grams topically three times a day. Apply to area of back and shoulder pain R3's Medication Administration Record (MAR) dated May 2025, included: -diclofenac Gel 1%; Apply to affected area three times daily. The MAR did not include a dose to administer. On May 6, 2025, at 8:59 a.m., the surveyor observed ULP-C prepare R3's medications which include an albuterol inhaler and diclofenac sodium gel. ULP-D shook the albuterol inhaler and administered one puff and a second puff immediately after the first puff. ULP-C did not wait one minute between puffs and did not offer or instruct R3 to rinse her mouth after administering the inhaler. ULP-C then put gloves on and administered a quarter size amount of diclofenac sodium gel to R3's back and shoulders. The surveyor inquired how ULP-C knew how much of diclofenac to administer. ULP-C stated she used what she thought was enough to cover R3's back and shoulders. ULP-C stated R3 would tell us if we used enough or needed to administer more. On May 7, 2025, at 9:40 a.m., CNS-B reviewed R3's MAR and stated the diclofenac sodium order did not include the amount to administer (4 grams) as the prescriber order indicated. In addition, CNS-B stated ULP-C should have waited one to two minutes in between administering each puff from the albuterol inhaler and offered R3 to rinse her mouth after use.	01750			

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01750	Continued From page 45 The directions for use document dated April 2024, indicated the following: -Step 1: To take the cap off the mouthpiece, squeeze the sides of the cap and pull it straight out. Look inside the mouthpiece for foreign objects and take out any you see. -Step 2: Hold the inhaler with mouthpiece down and shake it well -Step 3: Breathe out through your mouth and push as much air from your lungs as you can -Step 4: Put the mouthpiece in your mouth and close your lips around it. Push the top of the metal canister firmly all the way down while you breathe in deeply and slowly through your mouth -Step 5: After the spray comes out, take your finger off the metal canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth -Step 6: hold your breath for about 10 seconds, or for as long as is comfortable. Breath out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait one minute and shake the inhaler again. Repeat steps 2 through step 6. The licensee's Medication and Treatment Administration and Delegation policy dated August 1, 2021, indicated the following: -the medications have current prescriber's orders on file -A RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750			

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01770	Continued From page 46	01770			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on May 5, 2025, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up. R4 was admitted on March 10, 2025, with diagnoses that included dementia. R4's service plan dated March 9, 2025, indicated R4 received services to include medication	01770			

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01770	Continued From page 47 administration. The service plan did not include medication set up. R4's Medication Administration Record (MAR) dated April 2025, included the following medications: -lorazepam 0.5 milligrams (mg); 0.5 mg tablet by mouth three times per day (anxiety) -olanzapine 2.5 mg; take one tablet by mouth one time per day (agitation/sleep) -sertraline 50 mg; take one tablet by mouth one time per day (anxiety) -Vitamin B12 1000 micrograms (mcg); take one tablet by mouth one time per day (supplement) -acetaminophen extra strength 500 mg; take two tablets by mouth every six hours as needed (pain) -lorazepam 0.5 mg; take one tablet by mouth as needed every six hours (anxiety) -olanzapine 2.5 mg; take one tablet by mouth as needed every four hours (agitation/sleep) -quetiapine 25 mg; take one-half tablet by mouth as needed every six hours (agitation) R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On May 7, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated she set up medications for four residents and would set them up for 90 days at a time. CNS-B stated she did not document the medication set up in the resident records. CNS-B stated she used an excel spreadsheet to track when she needed to order medications from the pharmacy for the four residents, but the spreadsheet did not include the required documentation for medication setup. CNS-B stated she was not aware of the required documentation for medication set up.	01770			

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01770	Continued From page 48 The licensee's Medication Management-Administration and Setup policy dated August 1, 2021, indicated a licensed nurse will correctly and accurately document any medication setup provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures	01790			

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01790	Continued From page 49 regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) completed training and competency for one of two unlicensed personnel (ULP-D) providing medications to residents for	01790			

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01790	Continued From page 50 unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on August 13, 2024, to provide direct care and services to the licensee's residents. On May 6, 2025, at 6:55 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On May 7, 2025, at 9: 43 a.m., clinical nurse supervisor (CNS)-B stated ULP-D had not been trained or competency tested for providing medications to residents for unplanned time away from home. The licensee's Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, indicated the nurse would train the unlicensed staff and determine the unlicensed staff competency to follow the procedures for giving medications to residents. No further information provided.	01790			

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01790	Continued From page 51	01790			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on April 1, 2021, with diagnoses that included diabetes. On May 6, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3.	01820			

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01820	Continued From page 52 R3's service plan April 17, 2025, indicated R3 received assistance with medication administration. R3's signed prescriber orders dated April 9, 2025, included: -ondansetron 4 milligrams (mg); dissolve 1 tablet (4 mg total) in the mouth every eight hours as needed for nausea or vomiting. R3's Medication Administration Record (MAR) dated May 2025, did not include the medication order for ondansetron 4 mg. On May 7, 2025, at 9:23 a.m., clinical nurse supervisor (CNS)-B stated the ondansetron was discontinued due to not using it. CNS-B stated R3's record should contain a prescriber order to discontinue the ondansetron, but an order could not be located. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the nurse was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter	01830			

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01830	Continued From page 53 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with medication administration. The following prescriber orders lacked evidence of being renewed annually: -Artificial Tears 1.4% ophthalmic solution; Administer one drop into both eyes as needed for dry eyes. 6-8 times per day as needed, order dated September 1, 2023. -albuterol 90 micrograms (mcg)/actuation inhaler; Inhale two puffs three times a day, order dated March 27, 2023. -bisacodyl 4 milligrams (mg); take two tablets (10 mg total) by mouth two times a day as needed for constipation; order dated August 9, 2022. -Corcidin Chest-Cough 10-200 mg; take one	01830			

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01830	Continued From page 54 capsule by mouth two times a day as needed for cough or chest congestion, order dated January 11, 2022. R3's record lacked an annual renewal of prescriber orders for the medications listed above. On May 7, 2025, at 9:24 a.m., clinical nurse supervisor (CNS)-B stated R3's prescriber orders as listed above had not been renewed at least annually as required. CNS-B stated they were waiting for R2's primary care provider to return their request for annual prescriber orders. The licensee's Medication and Treatment Order policy dated August 1, 2021, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days		01830		
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		01940		

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01940	Continued From page 55 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R2 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).	01940			

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01940	Continued From page 56 The findings include: R2 R2 was admitted on March 15, 2023, with diagnoses that included Alzheimer's disease. On May 6, 2025, at 8:02 a.m., the surveyor observed R1 wearing bilateral lower extremity compression stockings. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include compression stockings, and vital signs. R2's signed prescriber orders included the following: -Gradient compression garments and supplies; [R2's name] requires this compression garment due to lower extremity. This is needed for the bilateral side of the body, order dated April 2, 2024. R2's record lacked prescriber orders for daily weights. R2's Medication and Treatment Assessment dated April 4, 2025, did not include compression stockings. R2's Comprehensive Nurse assessment dated April 4, 2025, under Treatment Plan indicated R1 did not utilize compression stockings. R2's Medication and Treatment Assessment Plan dated April 4, 2025, lacked the following: -statement of the type of service that will be provided; compression stockings -documentation of specific resident instructions relating to the treatments or therapy administration, for daily weights and compression	01940			

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01940	Continued From page 57 stockings. R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. On May 6, 2025, at 9:12 a.m., the surveyor observed unlicensed personnel (ULP)-C apply bilateral compression stockings to R3's lower extremities. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, and compression stockings. R3's signed prescriber orders included the following: -Gradient Compression garments; [R3's name] requires this compression garment due to peripheral edema. This is needed for the bilateral side of the body, order dated November 4, 2022. R3's record lacked prescriber orders for daily weights. R3's Medication and Treatment Assessment Plan dated April 4, 2025, lacked the following: -documentation of specific resident instructions relating to the treatments or therapy administration for daily weights and compression stockings. On May 7, 2025, at 9:33 a.m., clinical nurse supervisor (CNS)-B stated R2 and R3's treatment plans lacked the required content as noted above. The licensee's Individualized Medication, Treatment, and Therapy Management Plans	01940			

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01940	Continued From page 58 policy dated August 1, 2021, indicated the medication, treatment, and therapy management plans will be current and updated when there are changes. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the registered nurse or licensed health professional will document instructions for the delegated tasks in the resident's record. 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 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 and 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	01970			

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01970	Continued From page 59 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on March 15, 2023, with diagnoses that included Alzheimer's disease. R2's service plan dated April 5, 2025, indicated R2 received assistance with services to include compression stockings, and vital signs. R2's signed prescriber orders included the following: -Gradient compression garments and supplies; [R2's name] requires this compression garment due to lower extremity. This is needed for the bilateral side of the body, order dated April 2, 2024. R2's record did not include a current order within the past 12 months for compression stockings. R2's record lacked prescriber orders for daily weights. R3 R3 was admitted on April 1, 2021, with diagnoses that included diabetes. R3's service plan April 17, 2025, indicated R3 received assistance with services to include blood glucose checks, weights/vitals, and compression stockings.	01970			

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01970	Continued From page 60 R3's signed prescriber orders included the following: -Gradient Compression garments; [R3's name] requires this compression garment due to peripheral edema. This is needed for the bilateral side of the body, order dated November 4, 2022. -daily blood pressure checks: please contact if patient's blood pressure is greater than 150/90 for possible medication adjustment, order dated November 4, 2022. R3's record did not include a current order within the past 12 months for compression stockings or daily blood pressure checks. R3's record lacked prescriber orders for daily weights. On May 7, 2025, at 9:34 a.m., clinical nurse supervisor (CNS)-B stated R2's record lacked prescriber orders for daily weights and did not have current prescriber orders for compression stockings. CNS-B stated R3's record lacked prescriber orders for daily weights and did not have current prescriber orders for compression stockings and daily blood pressure checks. CNS-B stated she faxed R2 and R3's primary care provider to obtain updated treatment orders. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the nurse was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed.	01970			

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01970	Continued From page 61 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 or has the potential to affect a large portion or all the residents). The findings include:	02140			

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02140	Continued From page 62 The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license effective February 1, 2025. During the entrance conference on May 5, 2025, at 9:36 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 May 7, 2025, at 8:21 a.m., LALD-A provided the following Certificate of Completion dated October 8, 2023: -Communicating with Individuals Living with Alzheimer's and Dementia -Activities for Individuals Living with Alzheimer's Disease -Supporting and Guiding Individuals through Dementia-Related Behaviors -All About Alzheimer's and Dementia -Recognizing and Reporting Abnormal Observations LALD-A stated the above training was completed through Home Care Pulse. 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 May 7, 2025, at 9:51 a.m., the surveyor, LALD-A and CNS-B reviewed the approved list of dementia care training programs and CNS-B stated she had not completed courses from the approved list. LALD-A stated he was unaware the Home Care Pulse training did not meet the	02140			

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02140	Continued From page 63 requirement according to the approved list provided by the commissioner. The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, indicated persons conducting such training will be qualified to train in the care of individuals with dementia. Qualification will include the following: -Two years of work experience related to Alzheimer's disease or other dementias, or in other health care, gerontology, or another related field, and: -has completed and passed training approved by MDH (Minnesota Department of Health). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for licensee's one resident (R1) with bed rails. This resulted in an immediate correction order issued on May 5, 2025.	02310			

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02310	Continued From page 64 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included anxiety and depression. R1's service plan dated March 28, 2025, indicated R1 received assistance with services to include grooming, dressing, repositioning, toileting, bathing, mobility/ambulation, transfers and medication administration. On May 5, 2025, at 10:55 a.m., the surveyor observed R1 sleeping in bed with a halo bed rail attached to the left side of R1's bed. R1's Comprehensive Assessment dated March 27, 2025, indicated R1 did not utilize side/bed rails. On May 5, 2025, at 1:40 p.m., unlicensed personnel (ULP)-C stated R1 would use the bed rail to pull herself up to a sitting position and used it when trying to stand up from her bed. R1's record lacked: - an assessment for the current bed rail use; - documentation of risk vs. benefits education discussion with R1 or R1's responsible party; - documentation R1's bed rail was used, installed, and maintained per manufacturer's instructions; and	02310			

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NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
(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
02310	Continued From page 65 - documentation R1's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). On May 5, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated the halo bar was installed to R1's bed when she enrolled with hospice on March 27, 2025. CNS-B stated R1's record did not include an assessment for the halo bed rail, documentation of risks vs. benefits education discussion with R1 or R1's representative, documentation the halo bed rail was used, installed, and maintained per manufacturer's instructions or documentation the halo bed rail was checked for recalls with CPSC. CNS-B stated it was an oversight and would complete the required assessment immediately. On May 5, 2025, at 1:53 p.m., licensed assisted living director (LALD)-A stated hospice provided R1's bed and halo bed rail and was not aware that it had to be assessed since it was provided by the hospice agency. The licensee's Bed Rail Expectations policy dated September 25, 2024, indicated the following: -prior to implementation of a halo or universal QBar bed rail, and initial bed rail assessment is completed. The assessment should be repeated with any change of condition, annually and with discontinuation. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
(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	
02310	Continued From page 66 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER ABILIT HOLDINGS (PRAIRIE MEADO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 5TH AVE NW KASSON, MN 55944		
(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
02310	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On May 5, 2025, the license implemented actions to mitigate the risk to R1. Scope and severity remain at I.	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Abilit Holdings Prairie Meadow
800 5th Ave NW
Kasson, MN 55944
Dodge County
Parcel:

Phone: 507-328-0395

License Info

License: HFID 24053

Risk:
License:
Expires on:
CFPM: Shantel Hrtanek
CFPM #: 42613; Exp: 10/15/2025

Inspection Info

Report Number: F7962251008
Inspection Type: Full - Single
Date: 5/5/2025 Time: 2:17:38 PM
Duration: 120 minutes
Announced Inspection: No
Total Priority 1 Orders: 6
Total Priority 2 Orders: 8
Total Priority 3 Orders: 20
Delivery: Emailed

New Order: 2-100 Supervision

2-102.11JKLMO *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

COMMENT: facility is not clean

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 2-100 Supervision

2-102.12DMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: certified food protection manager certificate not posted

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 2-100 Supervision

2-103.11B *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0035B The person in charge must ensure only authorized persons are permitted in food preparation, food storage, and warewashing areas of the establishment.

COMMENT: many people entered the kitchen during the inspection, non washed their hands nor wore a hairnet

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

! New Order: 3-200B Food Characteristics:Receiving: temperature, condition

3-202.11A *Priority Level: Priority 1 CFP#: 12*

MN Rule 4626.0165A Discontinue sale or service of TCS foods not received at a temperature of 41 degrees F (5 degrees C) or below.

COMMENT: two boxes, and basket of individually packaged pats of whipped butter 73.6 deg

Rose area: container of partially melted butter 79.3 degrees

discard all

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers3-304.12B *Priority Level: Priority 3 CFP#: 43**MN Rule 4626.0275B* Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

COMMENT: scoops and handles lying in ingredient bins

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***! New Order: 3-500A Microbial Control: cooling**3-501.14A *Priority Level: Priority 1 CFP#: 20**MN Rule 4626.0385A* Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

COMMENT: Chicken and Gravy

12:30 taken out of hot holding serving line

12:45 put into deep plastic container with lid

12:15 container put into upright cooler

2:15 temperature taken by inspector

placed in shallow metal pan and put onto top shelf of freezer to cool quickly to 70 degrees

3:25 temperature taken

discarded did not reach 70 degrees in 2 hours

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 3-500A Microbial Control: cooling**3-501.15A *Priority Level: Priority 2 CFP#: 33**MN Rule 4626.0390A* Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

COMMENT: deep containers, tightly covered, heavy condensation inside container and under the lids; chicken and gravy, gravy, chicken

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***! New Order: 3-500B Microbial Control: hot and cold holding**3-501.16A2 *Priority Level: Priority 1 CFP#: 22**MN Rule 4626.0395A2* Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: Bulk milk dispenser; gallon milk 43deg, tomato juice 48 deg

Not under refrigeration; whipped butter pats 73.6deg

Rose area: butter 79 deg

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 3-500C Microbial Control: date marking**3-501.17A *Priority Level: Priority 2 CFP#: 23**MN Rule 4626.0400A* Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT: no date on container of gravy, chicken, sausage patties

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***! New Order: 3-800 Highly Susceptible Population**3-801.11C *Priority Level: Priority 1 CFP#: 26**MN Rule 4626.0447C* Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

COMMENT: shell eggs not pasteurized

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 4-200 Equipment Design and Construction4-201.11AMN *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0506A* Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.COMMENT: roaster, remove from facility
domestic refrigerator. remove from facility*Comply By: 6/2/2025 Originally Issued On: 5/5/2025***New Order: 4-200 Equipment Design and Construction**4-203.12 *Priority Level: Priority 2 CFP#: 36**MN Rule 4626.0560* Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

COMMENT: Rose area:

three independent thermometers in upright domestic refrigerator 2 reading 45 degrees, 1 reading 50 degrees, food temperatures taken during the inspection indicate the unit is holding at 41 degrees or lower

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 4-200 Equipment Design and Construction**4-203.13 *Priority Level: Priority 3 CFP#: 48**MN Rule 4626.0563* Replace the pressure gauge on the dishwasher with one that is accurate to 2 PSI in the range indicated on the manufacturer's data plate the 15 to 25 PSI range.

COMMENT: pressure gauge on dish washing machine 8 psi

*Comply By: 5/19/2025 Originally Issued On: 5/5/2025***New Order: 4-200 Equipment Design and Construction**4-204.11 *Priority Level: Priority 3 CFP#: 56**MN Rule 4626.0565* Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

COMMENT: line of drips on edge of hood

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36**MN Rule 4626.0620A* Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: no thermometer in bulk mil dispenser

*Comply By: 5/7/2025 Originally Issued On: 5/5/2025***New Order: 4-400 Equipment Location and Installation**4-402.11A *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0725A* Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

COMMENT: caulk around dish washing machine moldy and deteriorating, remove, clean/sanitize, replace

*Comply By: 5/19/2025 Originally Issued On: 5/5/2025***New Order: 4-400 Equipment Location and Installation**4-402.12D *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0730D* Install four inch legs on counter-mounted equipment that is not easily movable or not sealed to the table.

COMMENT: ice machine is not elevated on 4 inch legs or sealed to the counter

Comply By: 5/12/2025 Originally Issued On: 5/5/2025

New Order: 4-500 Equipment Maintenance and Operation4-501.11AB *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: bulk milk dispenser has ice build up in the interior of the unit, dripping down on the containers stored in the unit, puddles in the bottom, dripping out of machine when opened

oven gives a loud boom when turned on

alarm goes off for unknown reason on dish washing machine

build up of debris on ice machine filter

dish washing machine not reaching sanitizing temperature

*Comply By: 5/12/2025 Originally Issued On: 5/5/2025***! New Order: 4-600 Cleaning Equipment and Utensils**4-602.11A *Priority Level: Priority 1 CFP#: 16**MN Rule 4626.0845A* Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

COMMENT: can piercing blade on table mounted can opener encrusted with food

surfaces of large mixer has build up of food debris, griddle, popcorn machine

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

COMMENT: ice machine dispenser area not clean

*Comply By: 5/7/2025 Originally Issued On: 5/5/2025***New Order: 4-600 Cleaning Equipment and Utensils**4-602.13 *Priority Level: Priority 3 CFP#: 49**MN Rule 4626.0855* Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

COMMENT: build up of food and debris on non-food contact surfaces throughout facility, pictures taken, including but not limited to; handles, counters, equipment, bulk milk dispenser interior, ice machine, fan, hood filters

Rose area: interior of dish washing machine, food debris in stove top burner pans

*Comply By: 5/7/2025 Originally Issued On: 5/5/2025***! New Order: 4-700 Sanitizing Equipment and Utensils**4-703.11B *Priority Level: Priority 1 CFP#: 16**MN Rule 4626.0905B* Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: dish washing machine thermometer sent through machine 158 degrees

discontinue using dish washing machine to sanitize, it may be used to wash and rinse, separate sanitizing basins must be set up and used until machine is repaired

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 4-900 Protecting Clean Items4-903.11A *Priority Level: Priority 3 CFP#: 44**MN Rule 4626.0955A* Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: dirty fan blowing clean dishes in dish washing area

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 4-900 Protecting Clean Items**4-903.11B *Priority Level: Priority 3 CFP#: 44**MN Rule 4626.0955B* Store all clean equipment and utensils in a self-draining position that permits air drying and covered and inverted.

COMMENT: clean utensils stored food contact surfaces up

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 4-900 Protecting Clean Items**4-904.11B *Priority Level: Priority 3 CFP#: 44**MN Rule 4626.0965B* Present clean knives, forks, and spoons that are not prewrapped in trays and holders so that only the handles are touched by employees or consumers.

COMMENT: clean spoons stored food contact surface up

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 4-900 Protecting Clean Items**4-904.13 *Priority Level: Priority 3 CFP#: 44**MN Rule 4626.0975* Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

COMMENT: wapped tableware has exposed food contact surfaces

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 5-200A Plumbing: approved materials/design**5-201.11B *Priority Level: Priority 3 CFP#: 51**MN Rule 4626.1040B* Maintain the plumbing system in good repair.

COMMENT: spray arm leaking picture taken

*Comply By: 5/12/2025 Originally Issued On: 5/5/2025***New Order: 6-100 Physical Facility Construction Materials**6-101.11A2 *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1325A2* Provide closely woven and easily cleanable carpet in customer areas.

COMMENT: equipment, popcorn machine stored in carpeted hallway

*Comply By: 5/7/2025 Originally Issued On: 5/5/2025***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.11 *Priority Level: Priority 2 CFP#: 10**MN Rule 4626.1440* Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

COMMENT: no soap at hand wash sink in prep area by mixer and can opener

*Comply By: 5/5/2025 Originally Issued On: 5/5/2025***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.12 *Priority Level: Priority 2 CFP#: 10**MN Rule 4626.1445* Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT: no disposable towels at hand wash sink in prep area by mixer and can opener

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-304.11B *Priority Level: Priority 3 CFP#: 56*

MN Rule 4626.1475B Design, install and operate all ventilation systems, furnaces, gas or oil-fired heaters, and water heaters according to Minnesota Rules chapters 1305, 1346, and 7511.

COMMENT: fan blowing in dish washing machine area blows steam from dishmachine into kitchen, hood is not capturing steam with fan turned off

Comply By: 5/19/2025 Originally Issued On: 5/5/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: trim on laminated cabinets missing, pictures taken

Comply By: 5/19/2025 Originally Issued On: 5/5/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C *Priority Level: Priority 2 CFP#: 38*

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

COMMENT: fly swatter sitting inside a piece of equipment on serving line, picture taken

Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: floor and wall surfaces soiled

Comply By: 5/7/2025 Originally Issued On: 5/5/2025

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

I acknowledge receipt of the Rochester District Office inspection report number F7962251008 from 5/5/2025

Shantel Hrtanek
Head Cook

Heather Flueger,
Public Health Sanitarian 3
507-206-2723
heather.flueger@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Abilit Holdings Prairie Meadow
Kasson
County/Group: Dodge County

Inspection Info

Report Number: F7962251008
Inspection Type: Full
Date: 5/5/2025
Time: 2:17:38 PM

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: upright freezer at 90 Degrees F.

Comment: 3:25 temperature taken

discarded did not reach 70 degrees in 2 hours

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: upright freezer at 85 Degrees F.

Comment: 3:25 temperature taken

discarded did not reach 70 degrees in 2 hours

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** gallon milk; **Temperature Process:** Cold-Holding

Location: bulk milk dispenser at 43 Degrees F.

Comment: gallon of milk inside bulk milk dispenser

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** tomato juice; **Temperature Process:** Cold-Holding

Location: bulk milk dispenser at 48 Degrees F.

Comment: pitcher of tomato juice inside bulk milk dispenser

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** whipped butter pats; **Temperature Process:** out of mechanical refrigeration

Location: on counter at 73.6 Degrees F.

Comment: 2 boxes, self-serve basket

discard

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** butter; **Temperature Process:** out of mechanical refrigeration

Location: in cupboard at 79.3 Degrees F.

Comment: Rose area:

container of butter in cupboard

discard

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** gallon milk; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Independent Thermometer; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 45 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** Independent Thermometer; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 50 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: Upright Cooler at 140 Degrees F.

Comment: middle of food

12:30 taken out of hot holding serving line

12:45 put into deep plastic container with lid

12:15 container put into upright cooler

2:15 temperature taken by inspector

placed in shallow metal pan and put onto top shelf of freezer to cool quickly to 70 degrees

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: Upright Cooler at 102 Degrees F.

Comment: top of food

12:30 taken out of hot holding serving line

12:45 put into deep plastic container with lid

12:15 container put into upright cooler

2:15 temperature taken by inspector

placed in shallow metal pan and put onto top shelf of freezer to cool quickly to 70 degrees

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: Upright Cooler at 90 Degrees F.

Comment: side of food

12:30 taken out of hot holding serving line

12:45 put into deep plastic container with lid

12:15 container put into upright cooler

2:15 temperature taken by inspector

placed in shallow metal pan and put onto top shelf of freezer to cool quickly to 70 degrees

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken and gravy; **Temperature Process:** Cooling

Location: upright freezer at 60 Degrees F.

Comment: 3:25 temperature taken

discarded entire container did not reach 70 degrees in 2 hours

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** gravy; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ham; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 35 Degrees F.

Comment: container of ham dated 5/4

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: gallon of milk
Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Abilit Holdings Prairie Meadow
Kasson
County/Group: Dodge County

Inspection Info

Report Number: F7962251008
Inspection Type: Full
Date: 5/5/2025
Time: 2:17:38 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** High Temp Dishwasher

Location: Dishwashing Area **Equal To** 158 Degrees F.

Comment: inspector thermometer run through machine 2 times

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F7962251008		Food Establishment Inspection Report		Page <u>1</u> of <u>1</u>		
 Rochester District Office Minnesota Department of Health 3425 40th Avenue NW, Suite 115 Rochester, MN 55901		No. of Risk Factor/Intervention/Violations		9	Date: 5/5/2025	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 2:17:38 PM	
		Score (optional)			Dur: 120 min	
Establishment: Abilit Holdings Prairie Meadow		Address: 800 5th Ave NW		City/State: Kasson, MN	Zip: 55944	Phone: 507-328-0395
License/Permit #: HFID 24053		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable						
Mark "X" in appropriate box for COS and/or R						
COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Supervision						
1	OUT	Person in charge present, demonstrate knowledge and performs duties				
2	OUT	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	OUT	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	OUT	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	OUT	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT 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						
Compliance Status				COS	R	
Safe Food and Water						
30	N/A	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33	X	Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	IN	Approved thawing methods used				
36	X	Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38	X	Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)				Follow-up: Follow-up Date:		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury

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