DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 16, 2025

Licensee
Ivy Hill Senior Care Inc
607 Northwest 2nd Avenue
Faribault, MN 55021

RE: Project Number(s) SL34045016

Dear Licensee:

On September 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 9, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

August 27, 2025

Licensee
Ivy Hill Senior Care Inc
607 Nw 2nd Avenue
Faribault, MN 55021

RE: Project Number(s) SL34045016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34045	A. BUILDING: _____ B. WING _____	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HILL SENIOR CARE INC	607 NW 2ND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34045016-0 On July 7, 2025, through July 9, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 16 residents; 15 receiving services under the Assisted Living Facility license. 1290: An immediate order was identified on July 7, 2025, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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

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0 660	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated May 6, 2025, indicated the licensee was a low risk. ULP-E was hired on March 16, 2024, to provide direct care services for the licensee's residents. ULP-E's employee's record contained a first-step TST administered on March 19, 2024, and read on March 21, 2024. ULP-E's employee record did not include evidence that a second step TST had been completed. On May 4, 2023, at 11:05 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-D's employee file did not include evidence a second TST had been completed. On July 9, 2025, at 9:01 a.m., house manager (HM)-B stated ULP-E had completed her TB testing through the county public health agency and was unsure why only a first step TST had been completed. HM-B further stated there may have been a shortage at that time; although was unable to provide documentation to support this. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three	0 660		

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0 660	Continued From page 5 components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's 8.16 Tuberculosis Screening policy dated April 15, 2022, indicated new staff shall have an IGRA blood test or a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 6 (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 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 the required content. This had the potential to affect all 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	0 680		

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0 680	Continued From page 7 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's Emergency Preparedness Manual last reviewed April 26, 2024, lacked the following required content: - Emergency prep testing requirements On July 7, 2025, at 11:20 a.m., licensed assisted living director (LALD)-A stated they had not been conducting full-scale exercises, mock disaster drills or tabletop exercises other than for fire safety, and was unaware of the requirement. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated April 15, 2022, indicated: Exercises and Drills - [Licensee name] will conduct, at minimum, two emergency drills every 12 months - these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to teat our emergency plan and to identify gaps and areas for improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 775	Continued From page 8	0 775		
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, record review and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on July 8, 2025, from 8:11 a.m. through 8:44 a.m., with house manager (HM)-B, the surveyor observed the fire alarm panel display read trouble, comm fault 1. HM-B stated that the system was monitored but there were issues with the phone lines. During interview on July 8, 2025, at 9:39 a.m. with HM-B the surveyor requested a copy of the most recent fire alarm testing and inspection report. HM-B provided a report from Nardini Fire Equipment dated 6/3/2025. The report indicated the system status was failed and listed the monitoring of panel was not working. HM-B stated	0 775		

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0 775	Continued From page 9 they didn't understand exactly what the issue was, but they had contacted the company to see what the facility could do to resolve the issue. HM-B asked if the system needed to be monitored. State Fire Code in Minnesota Rules, chapter 7511 requires buildings equipped with automatic sprinkler systems to have alarm, supervisory and trouble signals automatically transmitted to an approved supervising station. Fire alarm systems shall be maintained as designed when the system was installed. HM-B verified the above conditions and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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	0 810		

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0 810	Continued From page 10 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 8, 2025, at 8:49 a.m., house manager (HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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	34045	A. BUILDING: _____ B. WING _____	07/09/2025

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IVY HILL SENIOR CARE INC	607 NW 2ND AVENUE FARIBAULT, MN 55021

(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
0 810	Continued From page 11 evacuation training, and evacuation drills for the facility. The licensees FSEP titled "Fire Emergency", undated, failed to include the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The 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. During an interview on July 8, 2025, at 9:39 a.m., HM-B stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290		

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	34045	A. BUILDING: _____ B. WING _____	07/09/2025

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01290	Continued From page 12 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS) with the assisted living license for one of 17 employees (activity director (AD)-C). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on July 7, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: AD-C was hired on August 28, 2023, to provide activities for the licensee's residents.	01290		

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01290	Continued From page 13 On July 7, 2025, at approximately 1:00 p.m., licensed assisted living director (LALD)-A provided the NETStudy 2.0 employee roster for health facility identification number (HFID) 34045 at the surveyor's request; AD-C was not included on the roster. On July 7, 2025, at 1:33 p.m., LALD-A reviewed the NETStudy 2.0 employee roster and AD-C's employee file and stated it did not include a background study. LALD-A further stated AD-C worked independently with the residents when providing activities. The licensee's 4.02 Background Studies policy dated April 15, 2022, indicated: No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On July 7, 2025, the licensee took immediate action; however, the scope and level remains at I.	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems	01440		

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01440	Continued From page 14 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date in which the individual begins working for the licensee for one of one unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on March 19, 2024, to provide direct care services to the licensee's residents.	01440		

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01440	Continued From page 15 ULP-E's employee record included a Employee Performance Review Form dated April 16, 2024. The form rated the employee (on a scale of one to four) on customer focus, mission & values, staff development, performance management, employee engagement, wellness, quality improvement, communication, professional development, financial stewardship, and job knowledge. The performance review was completed/signed by house manager (HM)-B. The form lacked documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On July 9, 2025, at 10:43 a.m., HM-B stated she had completed ULP-E's 30-day supervision; although did not have a nursing degree. HM-B further stated the 30-day review did not include observation of a delegated task by an RN and was unaware of the requirement. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated April 15, 2022, indicated: Staff who provide delegated nursing or therapy tasks to resident at [licensee name] will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems an solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. 1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440		

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01440	Continued From page 16 individual begins working for [licensee name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620		

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01620	Continued From page 17 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01620		

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01620	Continued From page 18 The findings include: R1 R1's unsigned, Service Plan printed July 8, 2025, indicated R1 received services including medication administration, behavior management, assistance with bathing, dressing, grooming, catheter care, ostomy care, wound care, support stockings, housekeeping, and laundry. R1's last three assessments were requested. Assessments dated December 8, 2024, March 30, 2025, and July 7, 2025, were provided. 112 days had passed between the December 2024, and March 2025, assessments (22 days late); and 99 days had passed between the March 2025, and July 2025, assessments (9 days late). R2 R2's unsigned, Service Plan printed July 8, 2025, indicated R2 received services including medication administration, blood glucose monitoring, behavior management, assistance with bathing, dressing, grooming, smoking program, housekeeping and laundry. R2's last three assessments were requested. Assessments dated December 8, 2024, March 30, 2025, and July 7, 2025, were provided. 112 days had passed between the December 2024, and March 2025, assessments (22 days late); and 99 days had passed between the March 2025, and July 2025, assessments (9 days late). On July 9, 2025, at 10:34 a.m., clinical nurse supervisor (CNS)-F stated many times she will complete resident assessments on paper first	01620		

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01620	Continued From page 19 and then type them into the electronic record at a later date when she has time. CNS-F further stated she had not scanned or kept a copy of the paper assessments as shredded the paper copies after inputting the information into the electronic record. CNS-F reviewed R1 and R2's last two assessments and stated they would be considered late according to the date in the electronic record. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated April 15, 2022, indicated: 3. 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 need 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=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 20 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised and signed by the resident to reflect the current services provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted on August 24, 2018, with diagnoses including bipolar disorder, paraplegia, and neurogenic bladder and bowel. R1's current unsigned, Service Plan printed July 8, 2025, indicated R1 received services including medication administration, behavior management, assistance with bathing, dressing,	01640		

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01640	Continued From page 21 grooming, catheter care, ostomy care, wound care, support stockings, housekeeping, and laundry. R1's last signed service plan was dated May 23, 2022. On July 8, 2025, at 9:24 a.m., the surveyor observed unlicensed personnel (ULP)-D providing wound care for R1. R2 R2 was admitted on May 1, 2018, with diagnoses including dementia, schizoaffective disorder, type II diabetes, neuropathy and edema. R2's unsigned, Service Plan printed July 8, 2025, indicated R2 received services including medication administration, blood glucose monitoring, behavior management, assistance with bathing, dressing, grooming, smoking program, housekeeping and laundry. R2's last signed service plan was dated May 23, 2022. On July 8, 2025, at 10:54 a.m., licensed assisted living director (LALD)-A stated R1 and R2's services had changed since the last signed service plan for each on May 23, 2022. LALD-A further stated she had not routinely had residents/resident representatives sign a new service plan when changes occurred. The licensee's 6.08 Service Plan policy dated April 15, 2022, indicated: 2. The service plan and any revisions shall include a signature or other authentication by [licensee name] and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Service plans shall be revised, if needed, based on resident reassessments and	01640		

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01640	Continued From page 22 monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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

Food & Beverage Inspection Report

Establishment Info

Ivy Hill Senior Care

607 NW 2ND AVENUE

Faribault, MN 55021
Rice County
Parcel:

Phone:

License Info

License: HFID 34045

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1034251053
Inspection Type: Full - Single
Date: 7/8/2025 Time: 1:00:32 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-800 Highly Susceptible Population**
3-801.11B *Priority Level: Priority 1 CFP#: 26*
MN Rule 4626.0447B Discontinue using unpasteuerized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.
COMMENT: Establishment currently uses unpasteurized eggs when making sunny-side up and over easy eggs for residents. Either begin using pasteurized eggs for these types of foods, or discontinue offering eggs that are not fully cooked.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-900 Protecting Clean Items
4-903.11A *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: Elevate the single-service items off of the floor in the basement storage areas.
Comply By: 7/29/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

Inspection conducted in conjunction with HRD.

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

I acknowledge receipt of the Mankato District Office inspection report number F1034251053 from 7/8/2025

McKenna Mathews

Dana Jean-Jerrow

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Ivy Hill Senior Care

Faribault
County/Group: Rice County

Inspection Info

Report Number: F1034251053
Inspection Type: Full
Date: 7/8/2025
Time: 1:00:32 PM

Equipment Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Strawberries**; Temperature Process:** Cold-Holding
Location: 2-Door Cooler at 40.3 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Ivy Hill Senior Care

Faribault
County/Group: Rice County

Inspection Info

Report Number: F1034251053
Inspection Type: Full
Date: 7/8/2025
Time: 1:00:32 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 166 Degrees F.
Comment:
Violation Issued?: No