Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2025

Licensee
Lincoln Lane Villa
503 East Lincoln Street Po 106
Hendricks, MN 56136

RE: Project Number(s) SL21339016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Lincoln Lane Villa. **Please contact Jodi Johnson at 507-344-2730 on or before September 23, 2025, to schedule the conference call.**

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21339	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN LANE VILLA	503 EAST LINCOLN STREET PO 106 HENDRICKS, MN 56136

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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: SL21339016-0 On July 28, 2025, through July 31, 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 15 residents; 15 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 380 SS=F	144G.33 Subd. 6 Violation of innovation variances	0 380		

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0 380	Continued From page 1 A failure to comply with the terms of an innovation variance shall be deemed to be a violation of this chapter. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comply with the terms of an innovation variance related to staffing. 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: On July 28, 2025, during the entrance conference at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the lifestyle and wellness coordinator (LWC)-B worked full time Monday through Friday- 8:00 a.m. until 4:30 p.m., a housekeeper Monday through Friday- 9:00 a.m. until 4:30 p.m., and operations manager (OM)-D assisted in serving the noon meal. On the weekends, there was an unlicensed personnel (ULP) working 8:00 a.m. through 12:30 p.m. Kitchen staff from the attached campus went to the assisted living (AL) to serve all meals, so they were in the AL building for all meals including the evening meal and the meals on the weekends. Beyond those hours, staff from the attached hospital would respond to pull cords and pendants. LWC-B and the ULP carried a pager when they were on duty, and the hospital staff carried the pager the rest of the	0 380		

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0 380	Continued From page 2 time. The licensee's letter with the Assisted living Licensure Innovation Variance Request dated August 1, 2022, indicated: "[Licensee] has completed and is submitting Innovation Variance Renewal for our 16 unit Assisted Living in [town, state]. The current Innovation Variance will expire September 3, 2022. The completion of this Innovation Variance is needed to meet the interpretation of Minnesota Department of Health Regulation 144G.41 subd. 1(12)(i-v) that ensures one or more persons are available 24 hours a day, 7 days a week who are responsible to respond to the requests of residents for assistance with health or safety needs. This is currently being met and has proven to be very effective in the following manner: Designated Certified Nursing Assistants are scheduled Monday through Friday from 7:30 am -8:00 pm and on weekends and holidays from 7:30 am -10:00 am and 4:00 pm -8:00 pm. During the timeframe that designated staff are not scheduled, licensed RN and LPN staff as well as Certified Nursing Assistant staff from the acute care and long term care settings respond to pull cord and pendant activation by the assisted living residents. They are notified by pager or bell activation on computer screen of resident needs. This in-house staff is located under the same roof and provides a quick response via attached corridor. It is truly less than a 2 minute walk. At this time we are respectfully requesting that an indefinite time frame be placed on this innovation variance request. Any time that this model is not working, we will be pro-active in revoking it and providing a different means to manage this regulation. It is of the utmost importance to us that the health and safety of our residents is met."	0 380		

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0 380	Continued From page 3 The licensee's Assisted living Licensure Innovation Variance Request Form dated August 1, 2022, signed by the facility's LALD at the time of the request, indicated the licensee was requesting a renewal of their variance and included the following: "a. Statute and subdivision(s) (as applicable) which the innovation variance is requested (be specific and detailed): MN Statute, 144G.41, subd. 1 (12)0-v) Ensure that one or more persons are available 24 hours per day, seven days per week who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (1) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions. b. Time period for which the innovation variance is requested: [Licensee] respectfully requests that this variance be granted indefinitely at this time. c. Specific alternative action the licensee proposes: The health, safety and welfare needs of all the residents of [Licensee] have been met and propose they continue to be met 24 hours each day in the following manner. Certified Nursing Assistants (CNA) are scheduled Monday through Friday from 7:30 am -8:00 pm. Weekends and holidays CNAs are scheduled 7:30 am -10:00 am and 4:00 pm -8:00 pm. Licensed RN, LPN and CNA staff from attached Acute care and Long Term Care settings know and understand their	0 380		

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0 380	Continued From page 4 responsibility to promptly respond to all calls when pendent's or pull-cords have been activated by the resident The acute care and long term care settings are located under the same roof and are attached via a short corridor. [Licensee] is a short walk that can be completed in less than two minutes from anywhere in the [Licensee] campus. d. Reason(s) for the request: Original Innovation Variance was granted 9/3/21 (September 3, 2021) with expiration date of 3/3/22 (March 3, 2022). The second Innovation Variance was effective 3/3/22 (March 3, 2022) with expiration date of 9/3/22 (September 3, 2022). This variance request is to meet the statute 144G.41 that ensures awake staff response to all resident needs for assistance 24 hours a day, seven days a week. It is our request that this variance be ongoing as we have ongoing assessment that this plan has been effective in meeting the needs of our residents. e. Explanation or justification of how the innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of residents, and is likely to improve the services provided: The above explained plan has been effective in providing quick response without delay by qualified, licensed, direct care staff trained to respond to the needs of the Assisted Living Residents. A pager is provided to nursing staff as well as the computer screen that alarms when a pull cord or pendent is activated." The licensee's Assisted living Licensure Innovation Variance Request Form, section titled Official Verification (page six of the form) identified, I certify I have read and understand, and attest to the following:	0 380		

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0 380	Continued From page 5 - I understand in accordance with Minn. Stat. section 144.051 Data Relating to Licensed and Registered Persons (https://www.revisor.mn.gov/statutes/cite/144.051), all data submitted on this application shall be classified as public information upon issuance of a variance. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (https://www.revisor.mn.gov/statutes/cite/144G), and Minnesota Rules, chapter 4659 (https://www.revisor.mn.gov/rules/4659/), governing the 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. - I have examined this request 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 belief, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - If this variance request granted, I agree to comply with any alternative measures or conditions required by the Minnesota Department of Health. - Owner or authorized agent signature of acknowledgment: The page was signed by the LALD at the time of the variance request. The licensee's Section 144G.33 Innovation Variance Decision form signed by the	0 380		

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0 380	Continued From page 6 commissioner on August 31, 2022, approved the variance indefinitely and included the following statements: "Alternative Measures or Conditions: The Minnesota Department of Health (MDH) approves this innovation variance request with the following conditions: 1)[Licensee] will maintain records and conduct quarterly audits to ensure they are offering services that will not adversely affect the health, safety, or welfare of the residents, and is likely to improve the services provided. MDH shall revoke or deny renewal of an innovation variance if: a) It is determined that the innovation variance is adversely affecting the health, safety, or welfare of the residents; b) The facility has failed to comply with the terms of the innovation variance; c) The facility notifies the commissioner in writing that it wishes to relinquish the innovation variance and be subject to the statute previously varied; or d) The revocation or denial is required by a change in law." The facility's posted staff schedule indicated the following: LWC - Monday through Friday 8:00 a.m. until 4:30 p.m. - Saturday and Sunday 8:30 a.m. until 12:30 p.m. Housekeeping - Monday through Friday 9:00 a.m. until 2:30 p.m. Dietary staff - 1-2 staff scheduled 6:00 a.m. until 2:30 p.m. and 2-3 staff scheduled 4:00 p.m. until 8:00 p.m. daily The schedule did not include a "Designated Certified Nursing Assistants are scheduled Monday through Friday from 7:30 am -8:00 pm and on weekends and holidays from 7:30 am	0 380		

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0 380	Continued From page 7 -10:00 am and 4:00 pm -8:00 pm" as indicated in the licensee's Assisted living Licensure Innovation Variance Request Form. The licensee's Direct Care Staffing Plan dated July 2025, indicated the following: 1. Staff of [Hospital and nursing home] that are scheduled and respond to the needs of the residents of [license name] will: i. Have the required experience, training and competency to provide care and services to the residents as appropriate for their position. 1. All Unlicensed Personnel providing direct care to the residents will a. Receive the required orientation and annual training with competency testing. b. Receive training and competency evaluation for additional nurse delegated tasks as needed based upon the resident service plan, assessment and/or evaluation. one on one orientation to new tasks to be provided. 2. licensed nursing staff will have a valid nursing license to practice in the State of Minnesota. 3. License nursing staff will receive required orientation and training pertinent to home health care and assisted living. 2. There will be 24 hour awake staff available to respond to resident assistance with health and safety needs. i. Each day between the hours of 8:00 pm and 7:30 am, and on weekends and holidays between 10:00 am and 4:00 pm, there will be direct-care staff able to respond to a resident's assistance with health and safety needs within a reasonable amount of time. This staff is provided through the acute care and/or long term care setting of the [hospital and nursing home]. This staff is located under one roof and is able to respond within a reasonable amount of time. 3. Staffing schedules will reflect the determination	0 380		

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0 380	Continued From page 8 of need for adequate number of staff. i. 1 - Staff will be available in house from 8 am - 4:30 pm on Monday through Friday ii. 1 -Staff will be available in house from 10 am - 4 pm on Saturday, Sunday and observed holidays. iii. 1 - Clinical Nurse Supervisor or designee will be scheduled Monday through Friday from 8:00 am - 4:30 pm iv. 1 - Clinical Nurse Supervisor or Licensed Nurse on rotating call 24/7 v. 1 - Licensed Assisted Living Director or designee will be scheduled Monday through Friday 8:00 am - 4:30 pm, on call 24/7 vi. Licensed RN scheduled coverage 24/7 located under one roof and able to respond with a reasonable amount of time. 4. Staff schedules will be posted outside the office area of [assisted living facility]. The staffing plan did not include "Designated Certified Nursing Assistants are scheduled Monday through Friday from 7:30 am -8:00 pm and on weekends and holidays from 7:30 am -10:00 am and 4:00 pm -8:00 pm" as indicated in the licensee's Assisted living Licensure Innovation Variance Request Form. On July 28, 2025, at 11:36 a.m., the surveyor observed OM-D and dietary aide (DA)-H serving a meal to the residents. On July 28, 2025, at 2:25 p.m., housekeeper (H)-J stated she worked Monday through Friday and only completed housekeeping tasks. H-J stated she does not provide any direct care to the residents. On July 28, 2025, at 3:36 p.m., the surveyor observed LWC-C doing an axe throwing activity with the residents.	0 380		

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0 380	Continued From page 9 On July 28, 2025, at 3:48 p.m., OM-D stated the dietary staff scheduled 4:00 p.m. until 8:00 p.m. come over to the AL from the campus kitchen, serve the meal, then either leave to assist in another area and return to clean up, or stay until residents finish eating and clean up. They do not stay at the AL the entire shift and are only there to serve the meal and clean up the meal. The dietary staff did not provide any direct care. On July 28, 2025, at 4:00 p.m., dietary manager (DM)-K stated the posted schedule was incorrect and included staff that do not work at the assisted living. There should only be one staff listed on each shift. Food is prepared at the campus kitchen. The staff scheduled for the AL will set up for the meal, dish up the meal in the kitchen, go to the AL and serve the meal, clean up and return to the kitchen. The staff are not in the AL the entire scheduled time, only for meal service, and they do not provide any direct care. On July 29, 2025, at 12:14 p.m., licensed assisted living director (LALD)-A stated the posted schedule was incorrect and should have only had the staff that go to the assisted living listed. There was not a CNA on duty as indicated in the variance request, there were CNAs available in the campus hospital and nursing home. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 380		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 10 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have an accurate daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required. 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	0 470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 11 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's census was 15 residents, 15 of whom received services under the assisted living license. On July 28, 2025, during the entrance conference at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the lifestyle and wellness coordinator (LWC)-B worked full time Monday through Friday - 8:00 a.m. until 4:30 p.m., a housekeeper Monday through Friday - 9:00 a.m. until 4:30 p.m., and operations manager (OM)-D assisted in serving the noon meal. On the weekends there was an unlicensed personnel (ULP) working 8:00 a.m. through 12:30 p.m. Kitchen staff from attached campus went to the assisted living (AL) to serve all meals, so they were in the AL building for all meals including the evening meal and the meals on the weekends. Beyond those hours, staff from the attached hospital would respond to pull cords and pendent's. LWC-B and the ULP carried a pager when they were on duty and the hospital staff carried the pager the rest of the time. The facility's posted staff schedule indicated the following: - one LWC - Monday through Friday - 8:00 a.m. until 4:30 p.m. - Saturday and Sunday - 8:30 a.m. until 12:30	0 470		

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	21339	A. BUILDING: _____ B. WING _____	07/31/2025

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0 470	Continued From page 12 p.m. - one housekeeper - Monday through Friday - 9:00 a.m. until 2:30 p.m. - dietary staff - 1-2 staff scheduled 6:00 a.m. until 2:30 p.m. and 2-3 staff scheduled 4:00 p.m. until 8:00 p.m. daily The licensee's Direct Care Staffing Plan dated July 2025, indicated the following: 1. Staff of [facility campus] that are scheduled and respond to the needs of the residents of [Facility] Assisted Living will: i. Have the required experience, training and competency to provide care and services to the residents as appropriate for their position. 1. All Unlicensed Personnel providing direct care to the residents will a. Receive the required orientation and annual training with competency testing. b. Receive training and competency evaluation for additional nurse delegated tasks as needed based upon the resident service plan, assessment and/or evaluation. one on one orientation to new tasks to be provided. 2. licensed nursing staff will have a valid nursing license to practice in the State of Minnesota. 3. License nursing staff will receive required orientation and training pertinent to home health care and assisted living. 2. There will be 24 hour awake staff available to respond to resident assistance with health and safety needs. i. Each day between the hours of 8:00 pm and 7:30 am, and on weekends and holidays between 10:00 am and 4:00 pm, there will be direct-care staff able to respond to a resident's assistance with health and safety needs within a reasonable amount of time. This staff is provided through the acute care and/or long term care setting of the [facility campus]. This staff is	0 470		

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0 470	Continued From page 13 located under one roof and is able to respond within a reasonable amount of time. 3. Staffing schedules will reflect the determination of need for adequate number of staff. i. 1 - Staff will be available in house from 8 am-4:30 pm on Monday through Friday ii. 1 -Staff will be available in house from 10 am - 4 pm on Saturday, Sunday and observed holidays. iii. 1 - Clinical Nurse Supervisor or designee will be scheduled Monday through Friday from 8:00 am - 4:30 pm iv. 1 - Clinical Nurse Supervisor or Licensed Nurse on rotating call 24/7 v. 1 - Licensed Assisted Living Director or designee will be scheduled Monday through Friday 8:00 am - 4:30 pm, on call 24/7 vi. Licensed RN scheduled coverage 24/7 located under one roof and able to respond with a reasonable amount of time. 4. Staff schedules will be posted outside the office area of [assisted living facility]. On July 28, 2025, at 11:36 a.m., the surveyor observed OM-D and dietary aide (DA)-H serving the meal to the residents. On July 28, 2025, at 2:25 p.m., housekeeper (H)-J stated she worked Monday through Friday and only completed housekeeping tasks. H-J stated she does not provide any direct care to the residents. On July 28, 2025, at 3:36 p.m., LWC-C was observed doing an axe throwing activity with the residents. On July 28, 2025, at 3:48 p.m., OM-D stated the dietary staff scheduled 4:00 p.m. until 8:00 p.m. come over to the AL from the campus kitchen,	0 470		

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0 470	Continued From page 14 serve the meal, then either leave to assist in another area and return to clean up or stay until residents finish eating and clean up. They do not stay at the AL the entire shift and are only there to serve the meal and clean up the meal. The dietary staff do not provide any direct care. On July 28, 2025, at 4:00 p.m., dietary manager (DM)-K stated the posted schedule was incorrect and included staff that do not work at the assisted living. There should only be one staff listed for each shift. Food is prepared at the campus kitchen. The staff scheduled for the AL will set up for the meal, dish up the meal in the kitchen, go to the AL and serve the meal, clean up and return to the kitchen. The staff are not in the AL the entire scheduled time, only for meal service, and they do not provide any direct care. On July 29, 2025, at 8:34 a.m., LWC-C was picking up trays from the residents' rooms. LWC-C stated she does not do any direct care. She carries the pager and responds to pull cords and pendants. If the resident needs assistance with something, she will notify the registered nurse. If she were accompanying a resident to an appointment or something and would be unable to respond, she will pass off the pager to the housekeeper. On July 29, 2025, at 12:14 p.m., licensed assisted living director (LALD)-A stated the posted schedule was incorrect and should have only had the staff that go to the assisted living listed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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, 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 a facility tour on July 28, 2025, at 10:30 a.m. with lifestyle and wellness coordinator	0 640		

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0 640	Continued From page 16 (LWC)-C, the surveyor observed a facility telephone in the dining room and in the entryway. There was no posting on or near the phone to call 911 in case of an emergency. LWC-C stated she was unaware it was required to be posted by the facility phones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 730 SS=F	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; (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	0 730		

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0 730	Continued From page 17 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. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary with the required content for one of one discharged 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 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:	0 730		

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0 730	Continued From page 18 R1's record included a hospital discharge summary indicating R1 was admitted to the hospital on May 3, 2025, and discharged on May 8, 2025. R1's Discharge Summary Report from the facility dated May 7, 2025, identified "With and increase in weakness, as well as cognitive changes, [R1] was discharged from the [facility] and is now residing in the [nursing home]." R1's record did not include a written discharge summary, provided to the resident, representative and case manager, which included the following required content: A. A summary of the resident's stay that includes diagnoses, courses of illness, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. 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; C. A reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over the counter medications; and D. A post discharge plan that is developed with the resident and, with the resident's consent, the residents 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 non-medical services the resident will need. On July 29, 2025, at 9:57 p.m., clinical nurse	0 730		

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0 730	Continued From page 19 supervisor (CNS)-B stated R1's discharge summary did not have the required content and she was unaware of what was required. The licensee's Resident Medical Record Contents policy dated July 2024, indicated the resident record would include a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 810		

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0 810	Continued From page 20 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 and 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 or has potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, at 3:05 p.m., maintenance manager (MM)-F and infection control/emergency preparedness (IC/EP)-G provided documents for the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The fire safety and evacuation plan did not	0 810		

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0 810	Continued From page 21 identify specific fire protection actions for staff and residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that staff and residents should follow in case of a fire or similar emergency. The current plan said it was for fire drills and listed the fire drill procedures. Nothing was addressed for an actual emergency for staff or resident procedures and movement and/or relocation in the event of a fire or similar emergency. IC/EP-G stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	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 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.	01290		

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01290	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the assisted living license for one of three dietary aides (DA)-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: The licensee's kitchen staff schedule dated July 20-August 2, 2025, indicated DA-E had worked in the assisted living facility on July 20, 21, 30, 2025, and was also scheduled August 1, 2, 2025, in the assisted living. On July 30, 2025, at 11:30 a.m., the surveyor observed DA-E independently serving meals to the residents. On July 29, 2025, at 10:58 a.m., an email was received from the human resources staff (HR)-L indicated DA-E had a background study affiliated with HFID 340, the licensee's campus hospital. HR-L stated DA-E did not have a background study affiliated with the assisted living facility HFID 21339. On July 29, 2025, at 12:14 p.m., licensed assisted living director stated the hospital and	01290		

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01290	Continued From page 23 nursing home staff that respond to pull cords and pendents were not affiliated with the assisted living license. The licensee's Background Studies policy dated October 2024, indicated assisted living facility employees would have background studies completed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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01370	Continued From page 24 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care by the licensee's one employee (lifestyle and wellness coordinator (LWC)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: LWC-C was hired on January 9, 2023.	01370		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 25 On July 28, 2025, at 11:36 a.m., the surveyor observed LWC-C visiting with residents during the meal and discussing the possible severe weather coming. On July 28, 2025, at 3:36 p.m., the surveyor observed LWC-C doing an axe throwing activity with the residents. On July 29, 2025, at 7:48 a.m., the surveyor observed LWC-C bringing Ensure (supplement) to R3's room and giving it to her to drink. On July 29, 2025, at 8:34 a.m., the surveyor observed LWC-C going room to room picking up breakfast trays and visiting with the residents. LWC-C stated she carries the pager and responds to any pendant or pull cord. She does not provide any cares, and if the resident required personal cares, she would call the nurse. LWC-C stated she picks up meal trays, does activities, takes the residents on outings, and will accompany them to appointments as she is able. If she is going to be out of the building for an extended time she will leave the pager with the housekeeper to respond to the pendent's and pull cords. LWC-C's Lifestyle and Wellness Coordinator Job Description dated November 2022, included: Qualifications - Enhance the activity program, quality of life and wellness of residents and complete necessary tasks in a timely manner. - Ability to follow sanitation and safety procedures as established by [licensee] dietary department. - Must be able to work with geriatric residents and understand their individual needs. - Must possess good interpersonal skills and	01370		

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01370	Continued From page 26 communication skills. - Must possess good organizational and prioritization skills. - Requires analytical skills and the ability to evaluate and solve problems. - Must exhibit a spirit of cooperation and teamwork. - Good leadership, initiative, and judgment skills preferred. Physical Demands and Special Characteristics - Motor coordination and manual dexterity required to coordinate hands, eyes, and fingers in providing client care and working with equipment. - Ability to perform tasks involving physical activity which may include moderate to heavy lifting and/or considerable standing and bending. - Visual and hearing ability sufficient to comprehend written and verbal communication. - Near visual acuity for reading and preparing reports, forms, charting etc. - Ability to exercise independent judgment and maintain emotional stability under stress. - Flexibility to handle changing situations and emergency needs. - Requires frequent talking, listening, reading, and writing. - Must be able to perform all physical requirements of the position. Job Accountability and Responsibility - Supports a high level of customer service to the assisted living residents and with other departments through communication, attitude, responsiveness and engagement. LWC-C's employee record lacked evidence LWC-C had been trained and/or competency tested in the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	01370		

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01370	Continued From page 27 to the supervisor designated by the facility; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. On July 31, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated LWC-C had been a certified nursing assistant (CNA) in the past but currently was not. CNS-B stated she thought LWC-C had completed the unlicensed personnel training, but there was no evidence it had been completed. In addition, LWC-C was not providing any cares for the residents and if they required cares, it would be completed by the CNAs that work for the company's home health agency, whom were also employed by the assisted living.	01370		

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01370	Continued From page 28 The licensee's Orientation, Training and Evaluation Policy dated July 2025, indicated the following: Training and competency evaluations for all unlicensed personnel must include the following: 1. Documentation requirements for all services provided 2. Reports of changes in the client's condition to the supervisor designated by the provider 3. Basic infection prevention and control procedures, including blood-borne pathogens 4. Maintenance of a clean and safe environment 5. Appropriate and safe techniques in personal hygiene and grooming, including: 1. Bathing; bed bath, sponge, tub and shower bath 2. Hair care; hair shampooing in sink, but and bed 3. Oral hygiene; care of teeth, gums, and oral prosthetic devices 4. Care and use of hearing aids; and 5. Dressing and assisting with toileting/elimination 6. Training on the prevention of falls for providers working with the elderly or individuals at risk of falls; 7. Standby assistance techniques and how to perform them 8. Medication, exercise, and treatment reminders 9. Basic nutrition, meal preparation, food safety, and assistance with eating 10. Preparation of modified diets as ordered by a licensed health professional 11. Communication skills that include preserving the dignity of the client and showing respect for the client and client's preferences, cultural background and family 12. Awareness of confidentiality and privacy 13. Understanding appropriate boundaries between staff and clients and the client's family	01370		

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01370	Continued From page 29 14. Recognizing emergencies and the knowledge of implementing emergency procedures to utilize in handling various emergency situations 15. 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=F	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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for the licensee's one employee (lifestyle and wellness	01380		

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01380	Continued From page 30 coordinator (LWC)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: LWC-C was hired on January 9, 2023. On July 28, 2025, at 11:36 a.m., the surveyor observed LWC-C visiting with residents during the meal and discussing the weather. On July 28, 2025, at 3:36 p.m., the surveyor observed LWC-C doing an axe throwing activity with the residents. On July 29, 2025, at 7:48 a.m., the surveyor observed LWC-C bringing Ensure (supplement) to R3's room and giving it to her to drink. On July 29, 2025, at 8:34 a.m., the surveyor observed LWC-C going room to room picking up breakfast trays and visiting with the residents. On July 29, 2025, at 8:34 a.m., LWC-C stated she carries the pager and responds to any pendent or pull cord. She does not provide any cares and if the resident requested personal cares, she would call the nurse. LWC-C picks up meal trays, does activities, takes the residents on outings, and will accompany them to appointments as she is able. If she is going to be	01380		

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01380	Continued From page 31 out of the building for an extended time, she will leave the pager with the housekeeper to respond to the pendants and pull cords. LWC-C's Lifestyle and Wellness Coordinator Job Description dated November 2022, included: Qualifications - Enhance the activity program, quality of life and wellness of residents and complete necessary tasks in a timely manner. - Ability to follow sanitation and safety procedures as established by [facility] dietary department. - Must be able to work with geriatric residents and understand their individual needs. - Must possess good interpersonal skills and communication skills. - Must possess good organizational and prioritization skills. - Requires analytical skills and the ability to evaluate and solve problems. - Must exhibit a spirit of cooperation and teamwork. - Good leadership, initiative, and judgment skills preferred. Physical Demands and Special Characteristics - Motor coordination and manual dexterity required to coordinate hands, eyes, and fingers in providing client care and working with equipment. - Ability to perform tasks involving physical activity which may include moderate to heavy lifting and/or considerable standing and bending. - Visual and hearing ability sufficient to comprehend written and verbal communication. - Near visual acuity for reading and preparing reports, forms, charting etc. - Ability to exercise independent judgment and maintain emotional stability under stress. - Flexibility to handle changing situations and	01380		

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01380	Continued From page 32 emergency needs. - Requires frequent talking, listening, reading, and writing. - Must be able to perform all physical requirements of the position. Job Accountability and Responsibility - Supports a high level of customer service to the assisted living residents and with other departments through communication, attitude, responsiveness and engagement. LWC-C's employee record lacked evidence LWC-C had been trained and/or competency tested in the following: (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. On July 31, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated LWC-C had been a certified nursing assistant (CNA) in the past, but currently was not. CNS-B stated she thought LWC-C had completed the ULP training, but there was no evidence it had been completed. LWC-C was not providing any cares for the residents and if they needed cares, it would be completed by the CNAs that work for the company's home health agency, whom were also employed by the	01380		

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01380	Continued From page 33 assisted living. The licensee's Orientation, Training and Evaluation Policy dated July 2025, indicated the following training may include: 1. Communication skills, including the ability to read, write, and verbally report clinical Information to clients, representatives (if any), caregivers and other agency staff. 2. Observation, reporting, and documenting of client status and the care or services furnished; 3. Basic knowledge of body functioning and changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel 4. Reading and recording temperature, pulse, and respirations of the client 5. Recognizing physical, emotional, cognitive, and developmental needs of the client 6. The physical, emotional and developmental needs of and ways to work with the population served by the home care agency 1. The need to respect the client, his/her privacy and property. 7. Range of motion and positioning. 8. Adequate nutrition and fluid intake. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	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	01470		

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01470	Continued From page 34 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 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;	01470		

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01470	Continued From page 35 (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 observation, interview, and record review, the licensee failed to ensure employee orientation included all required content for three of three dietary aides (DA-E, DA-H, DA-I). 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: DA-E DA-E was hired on January 2, 2025, and served meals to the licensee's residents. The licensee's dietary work schedule dated July 20, 2025, through August 2, 2025, indicated DA-E had worked in the assisted living facility on July	01470		

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01470	Continued From page 36 20, 2025. DA-E's employee record lacked evidence of the following required orientation: (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; (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. DA-H DA-H was hired on November 8, 2019, and began providing meal service to residents under the assisted living license on August 1, 2021. The licensee's dietary work schedule dated July	01470		

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01470	Continued From page 37 20, 2025, through August 2, 2025, indicated DA-H had worked in the assisted living facility on July 22, 23, 24, 26, 27, 28, and 29, 2025. On July 28, 2025, at 11:36 a.m., the surveyor observed DA-H serving meals to the residents. DA-H's employee record lacked evidence of the following required orientation: (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; (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. DA-I	01470		

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01470	Continued From page 38 DA-I was hired on March 19, 2024, and served meals to the licensee's residents. The licensee's dietary work schedule dated July 20, 2025, through August 2, 2025, indicated DA-I had worked in the assisted living facility on July 21, 23, 26, and 27, 2025. DA-I's employee record lacked evidence of the following required orientation: (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; (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.	01470		

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01470	Continued From page 39 On July 28, 2025, during the entrance conference at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the lifestyle and wellness coordinator (LWC)-B worked full time Monday through Friday-8:00 a.m. until 4:30 p.m., a housekeeper Monday through Friday-9:00 a.m. until 4:30 p.m., and operations manager (OM)-D assisted in serving the noon meal. On the weekends, there was an unlicensed personnel (ULP) working 8:00 a.m. through 12:30 p.m. Kitchen staff from the attached campus went to the assisted living (AL) to serve all meals, so they were in the AL building for all meals including the evening meal and the meals on the weekends. Beyond those hours, staff from the attached hospital would respond to pull cords and pendent's. LWC-B and the ULP carried a pager when they were on duty and the hospital staff carried the pager the rest of the time. On July 31, 2025, at 11:00 a.m. CNS-B stated all staff including the ancillary staff from the kitchen, hospital and nursing home should have orientation in all required topics. CNS-B stated she was unaware the assisted living orientation was not being completed by the ancillary staff. The licensee's Orientation, Training, and Evaluation policy dated July 2025, indicated all staff providing and supervising assisted living services must complete an orientation before providing care to assisted living residents. The orientation may be incorporated into the annual training requirement. The orientation need only be completed once for each staff person and is not transferable to another provider. The orientation must include the following topics: 1. Overview of sections 144A.43 to 144A.4798 2. Introduction and review of all provider policies and procedures related to the provision of	01470		

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01470	Continued From page 40 assisted living services 3. Handling of emergencies and use of emergency services 4. Compliance with and reporting of maltreatment of vulnerable adults. 5. Assisted Living Bill of Rights 6. Handling of client's complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complains and the Common Entry Point 7. 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 41 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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	01500		

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01500	Continued From page 42 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (lifestyle and wellness coordinator (LWC)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LWC-C was hired on January 9, 2023. On July 28, 2025, at 11:36 a.m., the surveyor observed LWC-C visiting with the residents during the meal and discussing the weather. On July 28, 2025, at 3:36 p.m., the surveyor observed LWC-C doing an axe throwing activity with the residents. On July 29, 2025, at 7:48 a.m., the surveyor observed LWC-C bringing Ensure (supplement) to R3's room and giving it to her to drink. On July 29, 2025, at 8:34 a.m., the surveyor observed LWC-C going room to room picking up breakfast trays and visiting with the residents.	01500		

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01500	Continued From page 43 LWC-C stated she carries the pager and responds to any pendent or pull cord. She does not provide any cares and if the resident requested personal cares, she would call the nurse. LWC-C picks up meal trays, does activities, takes the residents on outings, and will accompany them to appointments as she is able. If she is going to be out of the building for an extended time, she will leave the pager with the housekeeper to respond to the pendants and pull cords. LWC-C's employee record lacked evidence of completing the following required annual training: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 31, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated LWC-C should have completed all the required annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

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01530	Continued From page 44 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors 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; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a 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 the initial 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;	01530		

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01530	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date for one of one employee (lifestyle and wellness coordinator (LWC)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: LWC-C was hired on January 9, 2023. On July 28, 2025, at 11:36 a.m., the surveyor observed LWC-C visiting with the residents during the meal and discussing the weather. On July 28, 2025, at 3:36 p.m., the surveyor observed LWC-C doing an axe throwing activity with the residents. On July 29, 2025, at 7:48 a.m., the surveyor observed LWC-C bringing Ensure (supplement) to R3's room and giving it to her to drink. On July 29, 2025, at 8:34 a.m., the surveyor observed LWC-C going room to room picking up breakfast trays and visiting with the residents.	01530		

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01530	Continued From page 46 LWC-C stated she carries the pager and responds to any pendent or pull cord. LWC-C does not provide any cares and if the resident requested personal cares, she would call the nurse. LWC-C picks up meal trays, does activities, takes the residents on outings, and will accompany them to appointments as she is able. If she is going to be out of the building for an extended time, she will leave the pager with the housekeeper to respond to the pendants and pull cords. LWC-C's employee record identified Alert, Lock down, Inform, Counter, Evacuate (ALICE) training is used in active shooter or violent perpetrator situations. LWC-C's record did not include the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2024. On July 2, 2025, at 4:45 p.m., licensed assisted living director (LALD)-A stated she was unaware the initial training on the new required topics was required to be completed by July 1, 2024, and all staff would have had the same training. On July 31, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she was unaware of the mental illness and de-escalation training and none of the staff would have completed it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 47 (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 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	01620		

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01620	Continued From page 48 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day assessment as required for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2025, at 9:30 a.m., the surveyor observed clinical nurse supervisor (CNS)-B setting up a medication caddy for R2. R2 began receiving services on July 1, 2024. R2's service plan dated July 2, 2025, indicated R2's services included medication set up. R2's record identified the following assessments:	01620		

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01620	Continued From page 49 - admission assessment dated July 1, 2024; and - comprehensive assessment completed August 27, 2024. R2's record lacked evidence a 14-day reassessment had been completed. On July 30, 2025, at 9:57 a.m. clinical nurse supervisor (CNS)-B stated R2's record did not include a 14-day assessment as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 50 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2) who received services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2025, at 9:30 a.m., the surveyor observed clinical nurse supervisor (CNS)-B setting up R2's medication caddy. R2's service plan dated July 2, 2025, indicated R2's services included medication set up. R2's service plan did not include: - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On July 31, 2025, at 11:00 a.m., clinical nurse	01650		

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01650	Continued From page 51 supervisor (CNS)-B stated R2's service plan did not include the schedule and methods of monitoring assessments or the the schedule and methods of monitoring staff. The service plan should include all the required content. The licensee's undated, Content of Service Plan policy indicated the service plan would include: - Schedule and methods of monitoring assessments - Schedule and methods of monitoring staff providing services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 52 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document all required information in the resident's record upon disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record included a hospital discharge summary indicating R1 was admitted to the hospital on May 3, 2025, and was discharged from the licensee on May 8, 2025. R1's Discharge Summary Report from the licensee dated May 7, 2025, identified "With and [sic] increase in weakness, as well as cognitive changes, [R1] was discharged from the [licensee] and is now residing in the [nursing home]." On July 30, 2025, at 9:57 a.m., clinical nurse supervisor (CNS)-B stated R1's medications had been given to the family, but it was not documented. CNS-B stated she called the family on July 29, 2025, and they confirmed they had received them; however, this was not	01910		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN LANE VILLA	503 EAST LINCOLN STREET PO 106 HENDRICKS, MN 56136

(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
01910	Continued From page 53 documented in R1's record. Further, if the phone call had been documented, not all the required content would have been included. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21339	A. BUILDING: _____ B. WING _____	07/31/2025

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LINCOLN LANE VILLA	503 EAST LINCOLN STREET PO 106 HENDRICKS, MN 56136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 54 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 ensure an individual treatment management plan was developed for the licensee's one resident (R3) receiving a treatment. 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: On July 29, 2025, at 7:48 a.m., the surveyor observed lifestyle and wellness coordinator (LWC)-C bringing Ensure (nutritional supplement) to R3's room and giving it to her. R3's Nutrition Assessment dated May 8, 2023, completed by a registered dietician (RD) indicated R3 had poor meat intake and recommended Ensure plus or Premier Protein supplements once daily. The most current Nutrition Progress Note dated May 16, 2025, indicated to continue the Ensure Plus or a high protein drink daily. R3's service plan signed July 9, 2025, indicated R3 received meals, housekeeping, and laundry.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 55 R3's service plan did not include the daily dietary supplement. R3's record did not include a current individualized treatment and therapy management record which contained the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On July 31, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated the administration of the Ensure was not on the service plan and there was no documentation that staff had been providing the Ensure to R3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

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	21339	A. BUILDING: _____ B. WING _____	07/31/2025

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LINCOLN LANE VILLA	503 EAST LINCOLN STREET PO 106 HENDRICKS, MN 56136

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01950	Continued From page 56	01950		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a licensed health professional instructed and specified, in writing, specific instructions for administering a treatment for the licensee's one resident (R3) with 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01950		

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01950	Continued From page 57 a large portion or all of the residents). The findings include: On July 29, 2025, at 7:48 a.m., the surveyor observed lifestyle and wellness coordinator (LWC)-C bringing Ensure (supplement) to R3's room and giving it to her. R3's Nutrition Assessment dated May 8, 2023, completed by a registered dietician (RD) indicated R3 had poor meat intake and recommended Ensure plus or Premier Protein supplements once daily. The most current Nutrition Progress Note dated May 16, 2025, indicated to continue the Ensure Plus or a high protein drink daily. There was no evidence a licensed health professional completed the following: - instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident, and demonstrated the ability to competently follow the procedures; and - specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. On July 31, 2025, at 12:20 p.m. clinical nurse supervisor (CNS)-B stated the staff had not been trained or competency tested for administration of the supplement. The licensee's undated, Delegation of Nursing/Therapy Tasks policy indicated Training/competency of the caregiver 1. Delegation of nursing/therapy tasks is specific to the resident and the unlicensed personnel	01950		

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01950	Continued From page 58 assigned to provide the care. 2. Unlicensed personnel will be trained to the task and will return demonstration of the task to be performed to establish competency. Training may be provided one-on-one or in a group. Each unlicensed personnel will be required to satisfactorily perform the delegated task to be deemed competent. 3. The unlicensed personnel will acknowledge that they are willing to accept the task being delegated. 4. Instructions will be specific, identifying exact steps to be followed. Reporting parameters will be included in the instructions with specific documentation guidelines for the unlicensed personnel as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	01960		

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01960	Continued From page 59 Based on observation, interview, and record review, the licensee failed to ensure documentation of a treatment was completed for the licensee's one resident (R3) receiving a treatment. 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: On July 29, 2025, at 7:48 a.m., the surveyor observed lifestyle and wellness coordinator (LWC)-C bringing Ensure (supplement) to R3's room and giving it to her. R3 began receiving on November 1, 2022. R3's Nutrition Assessment dated May 8, 2023, completed by a registered dietician (RD) indicated R3 had poor meat intake and recommended Ensure plus or Premier Protein supplements once daily. The most current Nutrition Progress Note dated May 16, 2025, indicated continue the Ensure Plus or a high protein drink daily. R3's service plan signed July 9, 2025, indicated R3 received meals, housekeeping, and laundry. R3's service plan did not include the dietary supplement.	01960		

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01960	Continued From page 60 R3's record did not include documentation of administration of the supplement. On July 31, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated the Ensure administration was not on the service plan and there was no documentation that staff had been providing the Ensure to R3. The licensee's undated, Delegation of Nursing/Therapy Tasks policy indicated documentation of the delegated task in the resident record must occur and include 1. Signature and title of the person who administered the medication, treatment or therapy. 2. Date and time of administration No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01960		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240		

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02240	Continued From page 61 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for two of two residents (R2, R3). This practice resulted in a level one violation (a	02240		

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02240	Continued From page 62 violation that will cause only 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: R2 On July 30, 2025, at 9:30 a.m., the surveyor observed clinical nurse supervisor (CNS)-B setting up a medication caddy for R2. R2 began receiving services on July 1, 2024. R2's record included Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021. R2's record lacked evidence he had received the Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, or the current one dated April 30, 2024. R3 On July 29, 2025, at 7:48 a.m., the surveyor observed LWC-C bringing Ensure (supplement) to R3's room and giving it to her to drink. R3 began receiving on November 1, 2022. R3's record included Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021. R3's record lacked evidence he had received the Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, or the current one dated April 30, 2024. On July 31, 2025, at 10:04 a.m., operations manager (OM)-D stated she was unaware the Bill of Rights was an old version that was in with the	02240		

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02240	Continued From page 63 admission paperwork. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

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

Lincoln Lane Villa
503 East Lincoln Street
P.O. Box 106
Hendricks, MN 56136
Lincoln County
Parcel:

Phone:

License Info

License: HFID 21339

Risk:
License:
Expires on:
CFPM: Rachell Christine Sprinkel
CFPM #: 113416; Exp: 10/26/2025

Inspection Info

Report Number: F7990251011
Inspection Type: Full - Single
Date: 7/30/2025 Time: 11:30:09 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

We discussed Employee illness, handwashing, and Norovirus Prevention. An employee illness log was onsite.

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 F7990251011 from 7/30/2025

Benjamin D. Ische

Rachell Christine Sprinkel

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Lincoln Lane Villa
Hendricks
County/Group: Lincoln County

Inspection Info

Report Number: F7990251011
Inspection Type: Full
Date: 7/30/2025
Time: 11:30:09 AM

Food Temperature: Product/Item/Unit: Hot Hold Meatball**; Temperature Process:** Hot-Holding
Location: Steam Table at 172 Degrees F.
Comment:
Violation Issued?: No